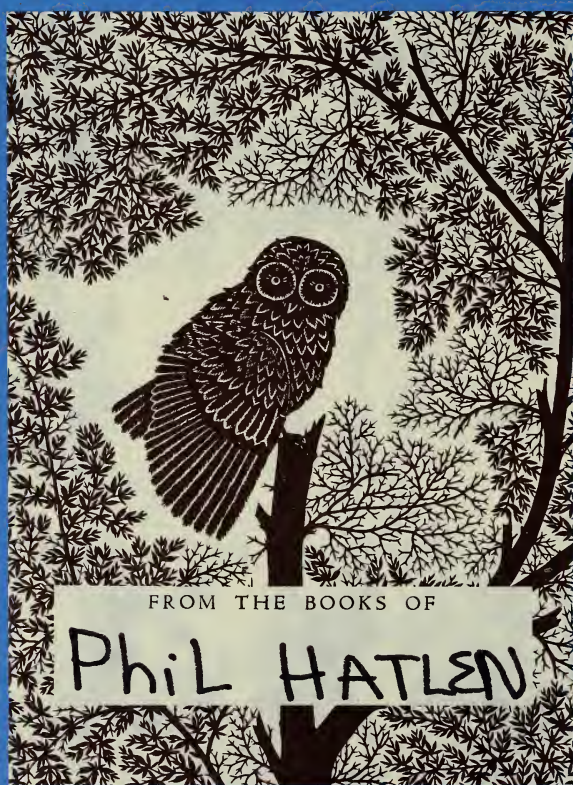


SERVICES
for
HANDICAPPED YOUTH
in
ENGLAND and WALES

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Services for Handicapped Youth in England and Wales

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Chapter 1.

Introduction

PURPOSE AND SCOPE OF STUDY

Provision of services for handicapped youth has increasingly concerned voluntary and governmental agencies in many countries in recent years. This concern has resulted in the formation of national and international groups devoted to the rehabilitation of the handicapped, groups which have stimulated and sponsored programs and research investigations covering many aspects of work with the handicapped. One such study, *Special Education of Physically Handicapped Children in Western Europe*, described the educational provisions for handicapped children in England (other than the mentally and emotionally handicapped) in one chapter.

The impression was gained during that investigation that some Americans professionally concerned with handicapped children and youth might benefit from a study of English practice. The English system of division of responsibility between local and national governments, church and lay groups, tax-supported and voluntary programs, differs somewhat from the American system. The English concept of the welfare state with its emphasis on "fair shares" which produced the National Health Service, the Youth Employment Service, and a variety of other national social services represents this effort to solve problems that are quite similar in both societies.

"Youth" are considered to be adolescents and young adults, or those from about 14 to 21 years of age, since legal age specifications for the assumption of certain kinds of adult responsibility or privilege, marking acceptance on the adult level, are variously defined in a range represented by those ages in our country. This is essentially the adolescent age span as conceived in the U. S. In this age group of 14 to 20 inclusive, there were 4,044,000 in England and Wales in 1957, and it is estimated that by 1973 there will be a total of 4,753,000 (193).

A handicapped youth as herein defined is any youngster in the 14-to-21 age range who has a physical, mental, or emotional deviation as compared with his peers which could interfere with his general adjustment, both his happiness and his efficiency.

The kinds of service comprise (1) educational services, including methods of ascertaining handicaps; (2) vocational assessment, guidance, and placement, whether through the Youth Employment Service, rehabilitation agencies, voluntary societies, or social welfare agencies; (3) vocational training and employment services provided by both statutory and voluntary groups; (4) medical services provided through the School Health Service, the National Health Service, rehabilitation programs, or in employment situations; (5) welfare services promoting physical and social well being, with special emphasis on the mentally ill and the mentally subnormal; and (6) the coordination of statutory and voluntary services. Emphasis is given to the services available to the population as a whole rather than to certain socioeconomic groups or to residents of heavily populated areas, though specific urban programs are at times used as illustrations.

The purpose of this study is to give a fairly comprehensive picture of the various types of service available to handicapped youth in England and Wales so that they may be compared with similar services in the United States.

Information concerning services for handicapped youth in England is almost always included in reports that refer to children and adults as well. Therefore information about provisions for both the pre-adolescent school child and the adult is incorporated, since youth as defined in this study are included in the upper age range of the school population and also in the ranks of adults in open or sheltered employment or receiving special care. Services for all youth, both handicapped and able-bodied, are described when necessary to give a complete account of services which are available to the handicapped.

If American students planning to work with handicapped youth, and professional persons already engaged in such work, can better understand their own roles and gain perspective on the problems they face through reading this account of similar programs in another country, the purpose of this study will have been achieved.

DEFINITIONS OF DISABILITIES

The English generally define disability in educational, employment, and medical or social-welfare terms. In the first type of definition the primary emphasis is on educability; the employability definition is the criterion used by the Ministry of Labour for registry of the handicapped; and the third type of definition, used in classifying mental defects, emphasizes potential response to medical treatment and eventual independent or custodial life.

An example of the educational definition is that for the blind as listed in the School Health Service and Handicapped Pupils Regulations for 1953 (No. 1156):

Blind: those who have no sight or whose sight is or is likely to become so defective that they require education by methods not involving the use of sight (188).

A similar kind of definition is given for the partially sighted, deaf, partially deaf (now called the partially hearing)*, epileptic, physically handicapped, those with speech defect, delicate, educationally sub-normal, and maladjusted. Specific definitions of the particular kinds of handicap included in each of these categories are given in the section on Special Education.

The multiply handicapped are not listed as a separate group in England. Some are included in the physically handicapped group, and others in the "educationally sub-normal" and "maladjusted" groups. The term "physically handicapped" as used in England has limited meaning and includes congenital and rheumatic heart disease, cerebral palsy, tuberculosis of the bones and joints, deformities or amputation of limbs, muscular dystrophy, hemophilia, and the after-effects of polio; in other words, it includes those suffering from severe and for the most part crippling conditions. It is therefore synonymous with the category of neuromuscular disabilities as used in the United States, plus cerebral palsy and cardiac difficulties.

The classification of "delicate" does not include heart disease; it does include children suffering from conditions of ill health, such as anemia, debility, chronic respiratory disease, and diabetes. In earlier days "delicate" children suffered chiefly from malnutrition and post-tuberculosis, but at present the chief ailments are respiratory defects—asthma and bronchitis in particular—or debility due to illness or poor home conditions (368).

The national registry for the disabled bases its definitions on the Disabled Persons (Employment) Act, 1944, which defines a disabled person as "a person who, on account of injury, disease, or congenital deformity, is substantially handicapped in obtaining or keeping employment, or in undertaking work on his own account, of a kind which apart from that injury, disease or deformity would be suited to his age, experience and qualifications." Here the stress is on employability, with or without training, in the open labor market, in a sheltered workshop, or at home.

A classification of disabilities, linked with a code developed by the Medical Research Council, has been devised by the Ministry of Labour and adopted, in abbreviated form, by the Ministry of Health

* The Handicapped Pupils and Special Schools Amending Regulations, 1962, amended the statutory definitions of pupils handicapped by impaired hearing; among the changes specified was one which substituted the term "partially hearing" for "partially deaf," in order to reflect a more positive approach to the use of residual hearing and thus underline the importance of early diagnosis (175).

in their Circular 32/51 to local authorities. Since separate provisions are made for the blind, the partially sighted, the deaf, and the partially hearing, the classification lists these groups separately from other forms of disability, which are grouped together into an inclusive category called "general classes." It should be pointed out that both the Ministry of Labour and the local health authorities compile registers on this basis, but whereas the register of the Ministry is confined to those capable of work (with or without training), the register kept by local authorities is more comprehensive, and is divided into five groups: (1) those capable of work under ordinary industrial conditions; (2) those who could work in sheltered workshops; (3) those who could only work at home; (4) those incapable of work; (5) children under 16 years of age, who are excluded from other groups (286). The last two classifications go beyond the scope of the national registry.

The medical and social-welfare type of definition applies to those with mental limitations of some kind, as described specifically in the Mental Health Act, 1959, which superseded earlier Mental Deficiency Acts. A detailed discussion of the development of terms related to the mentally subnormal and mentally disturbed is given in the 1957 Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, with recommendations for changes in terminology that were reflected in the Mental Health Act, 1959. This Act defines an inclusive category of mental disorder as "mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind." The subcategory of "arrested or incomplete development of mind" includes subnormality and severe subnormality. Subnormality in turn is defined as a state of arrested or incomplete development of mind (not amounting to severe subnormality) which includes subnormality of intelligence and is of a nature or degree which requires or is susceptible to medical treatment or other special care or training of the patient. Severe subnormality is defined as a state of arrested or incomplete development of mind which includes subnormality of intelligence and is of such a nature or degree that the patient is incapable of living an independent life or of guarding himself against serious exploitation, or will be so incapable when of an age to do so (218).

A detailed differentiation between the educationally subnormal and the mentally subnormal is discussed in the section on Special Education. Definitions based on IQ's alone have been found inadequate.

INCIDENCE AND PREVALENCE OF DISABILITIES

There are various sources from which data or estimates concerning the incidence of different categories of handicap may be obtained:

1. Annual reports from local education authorities concerning children for whom special educational provisions have been made.
2. Annual reports from local health authorities concerning all persons for whom certain medical and welfare provisions have been made.
3. Lists of persons on the national registry maintained for the handicapped by the Ministry of Labour.
4. Lists of persons on the registers of local health authorities.
5. Membership of organizations devoted to the interests of specific handicapped groups.
6. Statistical extrapolations beyond the data obtained in local or regional research surveys.

There are many reasons why the totals or estimates presented may not be accurate; these reasons are discussed at various points in the following chapters. It should be emphasized, however, that whatever shortcomings the English attribute to such data, their statistics are undoubtedly more complete than similar statistics found in any other country—of course including the United States. Both official government figures and estimates from voluntary groups are referred to in the following discussion. Some incidental ailments are included in government health and welfare reports, such as goiter and venereal disease, but since these are not considered primary handicapping conditions within the scope of this study, they will not be discussed here.

It is generally recognized as highly desirable to report and register handicapping or disabling conditions. The chief purpose is to provide the following:

1. Data concerning the size of each group for whom services are needed.
2. A basis for future planning of services and facilities.
3. A basis for referral of the child to the special services or agencies which he needs.
4. A basis for research.

At the same time, it is generally believed that any very formal system of general registration would not be useful, for the figures might not be accurate when received. There is widespread public resistance to the idea of compulsory registration, as indicated by the government's inability to introduce any system of compulsory registration since the end of World War II.

No figures relating to any category of handicap are available specifically for the 14-to-21 age range covered in this study. The type of incidence and prevalence data available vary somewhat from

one category of disability to another. This information is included in other sections where provisions for different disability groups are discussed.

Changes in the incidence of various handicapping conditions are reflected in a changing pattern of provisions for them. There is little need for sanatoria schools in England now. Schools for malnourished or delicate children have almost disappeared. There are more schools for the cerebral palsied, although this probably means not so much an increase in their numbers as an increase in public awareness of and concern about their needs. Since spina bifida and muscular dystrophy cases are living longer, they need services over a longer period of time. As already indicated, more provisions are also needed for multiply handicapped youngsters because more of them are now enabled to survive.

In the changing pattern of disability, tuberculosis is no longer a serious problem in schools because the incidence in the school-age group in England and Wales is now less than a third of what it was ten years ago. Oxford, with a school population of 14,200, had the distinction in 1960 of having no notifications of either pulmonary or non-pulmonary tuberculosis in the school-age group (183). Though miniature mass radiography has revealed that girls appear to be susceptible to minimal pulmonary tuberculosis, there is no evidence of a general rise in adolescent tuberculosis such as occurred some 10 to 15 years after World War I. Women between the ages of 15 and 34, and men over 45, are found to be the age groups with the greatest prevalence of tuberculosis.

Other changes include the sharp decrease in incidence of polio; this is rapidly coming under control as shown by the fact that the total notifications for 1960 were only about one-third those for the year before. Likewise the incidence of, and deaths from, rheumatic fever have decreased steadily, and as a result heart hospitals and residential schools for rheumatic children are now turning over some or all of their beds to children with other handicaps. In most "rheumatism" clinics, there are more children with congenital heart disease and functional murmurs than with rheumatic heart lesions.

Members of the Inspectorate and Medical Officers of the Ministry of Education presented a report on provisions in the northwest region for physically handicapped and delicate children. Their study of the day schools showed changes in the types of children being admitted; the degree of physical handicap is in general increasingly severe, and a higher proportion of the children are suffering from congenital illness. The report recommended that day special schools be adequately equipped to meet the needs of the full range of physical handicaps represented in this group, and that new schools should be planned on the assumption that a higher proportion of severely handicapped children would attend in the future. They made de-

tailed recommendations about the care and education of children in the region suffering from cerebral palsy, muscular dystrophy, and spina bifida. A similar study in the midland region was conducted in 1962.

General improvement in individual health and in housing conditions resulting from a widening program of public services, which permits increasing efficiency in the control of environmental factors producing handicapping conditions, has produced a situation in which congenital defects are now the main causes of some of the major handicaps of childhood—blindness, deafness, orthopedic handicap, and mental retardation—and inevitably some children have more than one defect. Thus the relative proportion of the multiply handicapped has grown. Severely “physically handicapped” children, especially those with cerebral palsy, are often also educationally subnormal, some have defective hearing, and still others are maladjusted, epileptic, or partially sighted. Deaf children, by the very nature of their defect, are often educationally retarded; some are maladjusted, partially sighted, or have other defects. Children with epilepsy so severe that they require treatment and education in special schools frequently have a number of handicaps; in one large special school more than half the children are also educationally subnormal and at least 12 to 15% are maladjusted.

It is interesting to note at this point the data presented at the 1960 White House Conference on Children and Youth concerning present incidence of various handicapping conditions among children, and the incidence forecast for 1970; figures are given in the thousands (44):

	1960	1970
Epilepsy	360	428
Cerebral palsy	366	437
Mentally retarded	2,198	2,624
Eye condition	10,274	12,260
Hearing loss	538	643
Speech handicap	2,460	3,012
Cleft palate	93	111
Orthopedic	1,940	2,315
Rheumatic fever	891	1,063

Since this list included only the most common handicapping conditions, tuberculosis and polio are not included. The incidence of rheumatic fever fails to indicate the rapid decrease reported by the English for their population.

Chapter 2.

Educational Services

SPECIAL EDUCATION

Education is under the control and direction of the Secretary of State for Education and Science, the present title of the responsible cabinet official, who from 1944 to 1963 was called the Minister of Education. Local education authorities are responsible for the provision of education but the Secretary, with the services of about 500 inspectors of schools, is responsible for seeing that these educational provisions are made adequately and efficiently, and that the policies of the government are being carried out. About 7 million children between the ages of 5 and 15, a million adolescents between the ages of 15 and 18, and a half million adults over 18 years of age attend schools and colleges full-time at an annual cost of approximately $1\frac{1}{2}$ billion dollars, or over 5% of the gross national product.

English education proceeds in the following stages: primary or infant, 5 to 7 years; junior, 7 to 11 years; secondary, 11 to 15 or 18 years (compulsory education requirements changed from 14 to 15 in 1947, and will change to 16 in 1970); and further education for those continuing in school either part-time or full-time but not at colleges or universities, which are described as higher education. At the secondary level students may be enrolled in: (1) a grammar school with an academic or pre-university program; (2) a technical school looking toward upper-level technical or engineering careers; (3) a secondary modern school, with a general or commercial program, usually terminal so far as full-time school is concerned; or (4) a comprehensive school, the name given to a school where two or more of the other programs are given in the same school.*

* Persons interested in a fuller discussion of the English educational system are referred to the most recent editions of two British Information Service publications on *Education in Great Britain* and *Books and Documents on Education in Great Britain*, as well as three major committee reports published by Her Majesty's Stationery Office: 15-18 (Crowther, Chairman), 1959-1960; *Half Our Future* (Newsom), 1963; and *Higher Education* (Robbins), 1963. Other references which may be of particular interest to American readers are: John Armitage, *Our Children's Education* (London, 1960); A. Harry Passow, *Secondary Education for All* (Ohio State University Press, 1961); and W. O. Lester Smith, *Education in Great Britain* (London, 1958).

Historical Development of Special Education

Specific governmental provisions for the education of handicapped children came late in the nineteenth century. Consistent with the dominant *laissez faire* philosophy of the times, it had formerly been thought that such concerns were best left to churches and charitably minded groups or individuals, or to entrepreneurs who could provide such services at a profit. This is not surprising since education for normal children did not become compulsory until 1880.

Voluntary organizations thus were pioneers in the provision of special education for handicapped children; they established the first schools for the blind and deaf in the late eighteenth century—for the blind in Liverpool in 1790, and for the deaf in London in 1792. The first secondary school for the blind, Worcester College, was founded in 1869, though it was not until 1946 that a secondary school for the deaf was established, followed by a secondary technical school for this group in 1955. Meanwhile the first schools for the physically handicapped were founded in Marylebone in 1851 and in Kensington in 1865. It was not until the twentieth century that special schools appeared for other groups such as the delicate and epileptic (368).

The Elementary Education (Blind and Deaf Children) Act, 1893, required school boards to enable blind and deaf children to receive education either by establishing a special school or by contributing to an existing school. This Act stipulated that blind children should receive such education from age 5 to age 16, and deaf children from age 7 to age 16, whereas normal children had a school-leaving age of 14. The Education (Defective and Epileptic Children) Act, 1899, permitted school authorities to make provision for the education of mentally and physically defective and epileptic children in addition to the earlier arrangements for the blind and deaf. These four categories were grouped together in the Education Act, 1921, which made provisions for both ascertainment and special educational treatment. But the requirement that the child be certified as mentally or physically defective before he could receive education in a special school, tended to stigmatize handicapped children and set them apart from their peers (93, 304).

Before the passage of the Education Act of 1944, provisions for handicapped children varied greatly. Although local authorities were obliged to provide special education only for children who were blind, deaf, epileptic, or mentally deficient, most local education authorities added other categories to this list, and pioneered in providing for other groups of handicapped children (7). Some children, no matter what their handicap, received excellent education, but in the case of a particular child this depended on such factors as where he lived, the quality of the program developed by the local education

authority, and also the traditions and vigor of the local volunteer societies.

For example, Liverpool pioneered in the provision of special schools for the handicapped in England (149). The Liverpool School for the Blind opened in 1790 and operated till 1898, when all the children from 5 to 16 years of age were transferred to a new school in Wavertree. The Hardman Street premises continued to be used for the technical training of the blind. The Liverpool School for the Deaf and Dumb was founded in 1825, and a new school close to the original institution was opened in 1904. Between 1900 and 1903 the city opened four schools for physically and mentally handicapped boys and girls. As it became apparent that it would be preferable to separate the mentally defective from the physically defective, and younger from older children, a special school for mentally defective boys was opened in 1920, and a new school for mentally defective girls and younger boys two years later. The first open-air day school was opened in 1930. By the end of 1957 the Education Committee was responsible for 17 day schools, 7 residential schools, 2 hospital schools, and 2 hostels.

After the 1944 Act was implemented, children in any local educational area had available to them opportunities and facilities that had earlier been found in only a comparatively few places such as Liverpool.

A major change found in the 1944 Act was the classification of handicaps in terms of educability, and the elimination of the certification requirement (93). Before 1944 there was no alternative for handicapped children but to be admitted to special schools. The 1944 Act brought them for the first time within the general framework of education, and made it a duty for the local education authority to provide for them, as for other children, an education suited to their ages, abilities and aptitudes.*

Steady improvement has occurred in the conditions prevailing in residential special schools for the handicapped. As one publication describes the earlier schools:

- These older institutions were supported by charity, supplemented later by meagre grants from public monies, so inevitably institutional life was conducted on a regimented, impersonal and spartan level. Teachers who taught in these institutional schools were unavoidably drawn into the supervision of the children out of school hours, which, in the limiting circumstances of numbers, equipment and build-

* The rapid expansion of the special educational services for the handicapped following the Education Act, 1944, is described in detail in the Ministry of Education report on "Education of the Handicapped Pupil 1945-1955." The historical development of special education over a period of two centuries is described in Pritchard's "Education and the Handicapped 1760-1960." An excellent bibliography is appended. The authors summarized the history of special education in their earlier publication on "Special Education for Physically Handicapped Children in Western Europe."

ings, became little short of child-minding. No attempt was made to integrate school and leisure-time activities into a unity. Today the original spartan charity and workhouse discipline outlook linger, from the stone-flagged floors to the self-sacrificing vocational demands made upon the teaching staff (271).

It was understandable that the improved schools which appeared in the late nineteenth century, which were operated by local school boards, found it difficult to discard the institutional ideas and practices of that period, some of which persisted into the 1920's, such as the practice of employing untrained and unqualified persons as supervisors and attendants. The social concerns developing between the two World Wars were reflected in improved conditions in residential establishments.

In brief, present-day special education in England means special educational treatment for children who are blind, partially sighted, deaf, partially hearing, physically handicapped, educationally sub-normal, epileptic, delicate, maladjusted, or suffering from speech defects not due to deafness. Education is given in regular schools, special schools, hospitals, or at home. Special schools have smaller classes than regular schools, and provide supplementary medical treatment including physiotherapy and speech therapy. The local education authority must not only provide free special educational treatment but also determine which children in their area need it.

Ascertainment

Who is handicapped? How is it decided that one child will receive special education and not another child? The term "handicapped" itself is so weighted with cultural and even linguistic connotations that it is almost meaningless except within the context of a particular society, or sub-culture of that society, at a specific time. English practice has evolved in response to the changing concepts of the responsibility society must assume for its members, and is currently reflected in the laws and procedures that determine selection for special education.

The term "ascertainment" refers to the discovery, classification, and referral of a handicapped child. In addition to the provision of education for children in general, the Education Act, 1944, specified that one of the responsibilities of the local education authority is to determine which children in the area require special educational treatment, and to provide it where necessary.

As indicated earlier, ten categories of handicapped pupils are defined in 1953 regulations from the Ministry of Education (now called the Department of Education and Science [188]); the blind, partially sighted, deaf, partially hearing, epileptic, physically handi-

capped, those suffering from speech defects not due to deafness, delicate, educationally subnormal, and maladjusted. The multiply handicapped are not listed as a separate group in these regulations.

The initial discovery of children who need special help is usually made by one of the following: (1) the parents; (2) the local education authority; (3) the school medical officer in a periodic medical examination of school pupils; (4) the school welfare officer; (5) personnel in maternal and child welfare clinics, whose services are used by between 90% and 95% of all mothers; (6) a public health nurse called a health visitor; and (7) the family physician, who may refer the child to a hospital for service. There is a close cooperation among all these individuals or agencies; if the child is found by a health agency, for example, he is referred to an educational agency, and if found by the latter he is referred to a health agency.*

In England great emphasis is placed on statistics, and the size of the country with its excellent communications and relatively homogeneous population has encouraged accurate reporting. Therefore figures on disabilities at an early age are fairly reliable. At the same time, some understandable obstacles to complete accuracy in case finding are encountered. Although it has been compulsory since 1915 to report all births to the local medical officer of health as a necessary prerequisite to the efficient care of mother and child, this does not mean a simultaneous reporting of handicaps (93). Some handicaps are not overtly apparent at birth, such as below-average mentality, and still others may develop later. Parents or midwife may not be able to identify certain forms of handicap accurately. Also the parents may be unwilling to recognize or admit the existence of a handicap because they feel that both they and the child are stigmatized by his attendance at a special school.

This attitude is a carryover of concepts concerning the early special schools, which were thought of as "abnormal places attended by grossly abnormal children," and as "dumping grounds to relieve the ordinary school, rather than as educational establishments in their own right" (39).

Fortunately parents are now much more likely to report their handicapped child. They are more acceptant of special education for their child because its value is more generally recognized, opportunities for such education are generally available, and mental and physical defects are not socially stigmatized in the same way as in the past.

From as early as 2 years of age a child may be examined at the request of the local education authority or the parent to see whether there is any disability of mind or body that requires treatment (93).

* Report by James Lumsden, Ninth World Congress of the International Society for Rehabilitation of the Disabled, Copenhagen, June 1963.

The local education authority is empowered by law to mandate special education for a child even against the wishes of the parents when it seems necessary, but no test case of this kind has yet arisen.*

An important contribution to the cause of accurate ascertainment is being made by a comprehensive longitudinal study of 16,000 children all born in the same week in March 1958. The task of finding these children began in June 1964, when the government education departments for England, Scotland, and Wales requested information from local education authorities. One aim of this study is to "investigate the way in which various handicaps are interrelated, and to examine the early data recorded before and after birth and the present provisions for medical, educational and social diagnosis and treatment which are available to the children and their families" (366). All children in the sample are to be identified who because of a physical, mental, or social handicap give concern to their parents, teachers, or others who care for them. As a result of investigations such as this long-term study, methods of determining the nature and extent of a child's handicap have been refined considerably in recent years. There is increasing awareness of the complexity of factors contributing to a child's behavior and level of development at any given time. This has led to more concern about the dangers of too facile and cursory a determination of his classification, particularly when the kinds of opportunities available to him are generally determined by his classification. Although the English have no legal category called the multiply handicapped, there is awareness of the frequency with which disabilities are associated in the same child, as in the case of speech problems with deafness or cerebral palsy, and of the way in which one handicap may produce another as in instances where emotional disturbances result from difficulties of adjustment occasioned by deafness or cerebral palsy.

It is thus recognized that the more serious mental or physical defects which necessitate special educational provisions are only part of a broad range of conditions which handicap the child to some extent and interfere with his optimal development. Ascertainment of handicaps in the school, for example, is usually incidental to the examination of children as a part of the general health program. Many mild deviations which are discovered may be easily corrected and taken into account in providing instruction in the regular school simply by acquainting the teacher with the situation.

A specific illustration of this principle is the fact that the ascertainment of children with more serious visual or auditory defects occurs as part of the comprehensive program for determining the nature and extent of sight and hearing defects in children attending regular schools. In 1961, 136,388 children were found to require treatment for defective vision (excluding squint), of whom 17,000 were enrolling in school for the first time. Tests for defective color vision are

given at age 10 or 11 to allow a change of choice of career or type of training if it is deemed necessary (183). In the past the visual tests were given at the same time as the periodic required medical examinations, but now that the law permits such examinations to be selective rather than routine, annual visual tests are given separately. In one study it was found that 40% of 45 children needing glasses would have had to risk a delay of at least a year before detection if there had been only routine general examinations; among these were 18-year-olds who would have had to wait two years for a routine test (183).

Other evidence similarly underscores the need for annual visual tests. Since myopia develops most frequently between 8 and 12 years, this fact emphasizes the need for annual checks of vision from age 10 on; in Birmingham, of the children examined for defective vision in 1960, 7.5% under 10 years of age, and 20.4% of those over 10 years of age, had myopia. Unlike the general medical and dental examinations, it is usually found that the children cooperate better in the visual tests when their parents are not present. Some health authorities find the family history important in the case of children with defective vision, and recommend the routine testing of all siblings of such children. Non-professional personnel can often be trained to give the visual tests (183).

More visual defects are found as the children grow older. A Middlesex report indicated that incidence rose from 8% at 5 years to about 30% at 16 years, with a higher percentage for girls at most age levels (183).

One problem with visually defective children is to get them to wear their glasses. With older children, especially girls, fashion and the appearance of the frames are often of primary importance, and some have complained that the choice of frames supplied by the National Health Service is too limited. At least if parents do buy frames outside the National Health Service provision, they do not need to pay for the lenses. Parents often fail to cooperate in getting their youngsters to wear their glasses. To assure their more regular use, children in Manchester are re-examined by ophthalmic medical officers six weeks after the prescription of glasses to see that the glasses have been obtained and are satisfactory; after that the youngsters are inspected periodically in school by school nurses to see that the glasses are worn regularly. In Cumberland older boys are told of the possibility that a visual acuity test might some day be required for a driver's license, in which case neglect of eyesight could have practical disadvantages (183).

Although as with visual defects certain more serious auditory defects may be first detected as part of the program of school medical examinations, it is now rare for deaf or partially hearing children to escape detection before entering school. In 1961 a joint circular was

issued by the Ministry of Education and the Ministry of Health on "Young Children Handicapped by Impaired Hearing" along with a memorandum on services for such youngsters; the purpose was to give guidance and information to hospital authorities, executive councils, and local medical committees involved in the ascertainment, diagnosis, and training of young deaf children (194). In addition to periodic tests, special referral of individual cases suspected of having hearing loss reveals additional cases. The late Lady Ewing devised a series of screening tests to be used for very young children, and also pioneered in providing courses of instruction for health visitors in the use of her methods. To save the time of the health visitors, tests are usually confined to children in an "at risk" group—those who for various reasons are more likely to have hearing loss. Parent guidance to enable them to train their children adequately at home is also undertaken. Babies are fitted with hearing aids just as soon as deafness is diagnosed (183).

Although audiometric testing of hearing has been most common—in 1960, 125 of the 146 local education authorities had one or more audiometers in use—it is generally agreed that the educational classification of children in regular schools who have defective hearing should not be made on the basis of pure-tone audiometry alone. Other factors must be considered such as the child's articulation, the fluency of his speech, and his ability to understand spoken language. It is becoming common practice to use both pure-tone audiometry and speech audiometry in tests, and to make out audiograms for each type. It is recognized increasingly that one cannot generalize about the deaf as a group, and that many factors must be taken into account such as the degree of hearing loss, the kind of hearing impairment involved, the time of onset of this impairment, the nature and extent of other organic defects which may be present, and the kind of education experienced at the time of assessment (183).

An example of an assessment program incorporating a consideration of a variety of defects associated with defective hearing is that of a survey made in the fall of 1963 in which 16,000 school children in the South East Glamorgan Health Division were tested. Teachers were asked to refer children in the following groups:

1. Children whose hearing had been suspected by the teacher as being below normal.
2. Children who for no obvious reason were not making satisfactory progress in school subjects.
3. Children with a definite speech defect such as defective consonants or imperfect or incomplete word formation, though children with lisps and stammers were not included.
4. Children showing clear signs of emotional maladjustment.

A full assessment of the children who needed intensive study included a physical examination and inspection of ear, nose, and throat; audiometry and a hearing test with test cards developed by the Royal National Institute for the Deaf; an interview by a teacher of the deaf to note language development, quality of speech, and educational achievement; and a case conference including the medical officer, special teacher of the deaf, and head teacher. Selection of the more limited number of children receiving this full assessment was made by the teaching staff of each of the schools visited during the survey (325).

An accurate assessment of the intellectual ability of children with severe physical handicaps presents many difficulties, where the physical limitations may obscure underlying potential especially when the tests used are not devised specifically with such handicaps in mind. One approach to this problem is the establishment of an assessment unit in a large hospital or in a university center where specialists in the separate fields involved can function as a team to diagnose the handicaps and estimate the child's ability (96). The deaf-blind assessment unit called "Pathways," established in connection with the Condover Hall School for the Blind in 1952, admits children for a short-term four-day assessment period, during which they are examined by the school doctor and the medical consultants who, with the help of the staff, prepare a report summing up the case history, giving a statement about the child's physical condition, and making an assessment of his educability. It is recognized that this assessment must be cautious in view of the child's multiple handicaps and the probable lack of stimulus in early years (337).

At a conference on deaf-blind children sponsored in London in 1961 by the Rubella Group for Deaf-Blind Children, it was recommended that each year from age two to school age, the deaf-blind child should have an assessment period of at least a week, with his mother or another familiar adult present, with a member of a special counselling service continuing to visit the family between assessment periods (337).

Comment should be made at this point about the ascertainment of thalidomide babies, with whom there has been only limited experience so far in view of the fact that most of them are now only a few years old. Experience at the Chailey Heritage Craft School indicates that it is impossible to generalize about them since the nature and extent of deformity varies from child to child. It is yet difficult to estimate their intelligence particularly since they lack so much tactile sensation and function, but it is believed that they represent a normal sample of the range of intelligence. Those with normal arms and hands but no legs or simply "flipper" feet should present relatively few problems, and when fitted with artificial legs should manage well in regular schools or day special schools. Those with legs and feet

but little more than hands or fingers at the shoulders should be able to manage arm prostheses, especially if shoulder joints are present; they may eventually write with feet, artificial arms, or teeth, as indicated by samples from older youngsters with similar limitations. Severely handicapped cases are those with all four limbs absent, or with only "flipper" limbs; they are more likely to be able to manage artificial legs than artificial arms. Some of these children may never achieve real independence in the activities of daily living. But most severely handicapped are those who have additional handicaps such as poor vision or even blindness, poor hearing, facial paralysis, heart lesions, or an impaired sense of balance.

However, dire emergencies seem always to call out the best in people. Certain it is that moves to meet the particular needs of the "thalidomide" babies are gathering momentum and creating a new awareness to the problems of the handicapped. It may well be that much of lasting help to other handicapped children will remain as a legacy long after the "thalidomide" babies have grown up and taken their place in society (19).

In ascertaining cerebral palsied children, the process of determining the child's special needs and the most appropriate placement dictated by these needs is somewhat more complex than for other disabilities. The Spastics Society has Assessment Panels for this purpose, composed of a pediatrician, an educational psychologist, and a social worker, though the exact combination of specialists is determined in part by the characteristics of the individual child. Local education authorities, local health authorities, and local doctors and hospitals cooperate by referring youngsters for this service, and have even requested that these services be extended to include other children in addition to those destined to attend the Society's centers and schools. It is now rare for local authorities to apply for the admission of a child to a specific school by name, for they usually send records and ask the Society to assess the child's needs. Children with multiple handicaps, who in a one-day assessment in London are found to be on the borderline between educability and unsuitability for formal education, are sent for a longer, residential assessment to the Society's Hawksworth Hall Assessment Centre. Here the child will stay for from three to twelve months in a teaching and therapy situation where he is periodically reassessed by an expert Panel. The Society sees each month at least 50 children of all degrees of physical and mental handicap (378). Parents must be reminded that the results of assessment as educable or ineducable are not to be interpreted as success or failure as in the case of school examinations.

Accurate ascertainment is especially important in the case of epilepsy; great care is taken before labeling a child an epileptic (203). Genuine medical characteristics must be dissociated from continuing

prejudices and misconceptions concerning epilepsy. Most people in England as in the U. S. still think that "once an epileptic always an epileptic," and unfortunately many physicians also share this view. Other misconceptions are that epilepsy is always associated with mental subnormality, or with a specific type of personality characterized by egocentricity and hypersensitivity. Yet actual data indicate a similar distribution of IQ's among epileptic children as compared with normal children. Personality disorders may occur, but caution must be exercised in attributing them to epilepsy without first investigating the environmental background of the child. Epilepsy does tend to run in families, but there are many types which have exogenous causes, and the intensity and frequency of seizures, whatever their origin, is related to psychological reactions caused by unfavorable social attitudes (183).

Although it was common practice in the past to judge mental characteristics in terms of physical signs, and therefore to associate epilepsy inevitably with low intelligence, as long ago as 1898 it was pointed out that epileptic children of normal intelligence whose attacks occurred no oftener than once a month were capable of attending regular schools, and therefore teachers should be instructed as to how they might deal with these attacks (304). Thus it was important that an accurate determination be made of both the severity and frequency of epileptic seizures, and of the child's intelligence. Only if the nature of these attacks made travel to school dangerous for them, or if their presence in school caused serious disturbance for the other children, should they be educated in residential schools.

The application of these recommendations occurred only slowly, however, following Binet's initiation of the objective measurement of intelligence in the early 1900's, and the gradual accumulation of more sophisticated medical knowledge which now makes possible a differentiation among various types of seizures, some of which are not truly epileptic, the causes of seizures, and a further differentiation among the forms of epilepsy itself and their implications concerning the special educational provisions needed by the child.

The classification of epileptic forms has changed markedly in the last two decades because of the development of electroencephalographic techniques. Epilepsy is now regarded as a *symptom* which may take many forms, ranging from a subjective tingling in an arm to a convulsion of the whole body with loss of consciousness. It has recently been defined as including "all attacks primarily cerebral in origin in which there is a disturbance of movement, feeling, behavior, or consciousness." The attacks are usually transient and recurrent, without an obvious, immediately precipitating extra-cerebral cause (183).

The old classification of idiopathic and symptomatic epilepsy has been found inadequate. Idiopathic epilepsy (epilepsy of unknown

origin) is relatively rare now in children who have been carefully investigated, since some cause can usually be found. Nor is a classification based on seizures considered adequate. Present usage classifies epilepsy on the basis of the site from which the epileptic discharge springs, since this has important bearing both on patient behavior and on mode of treatment.

Two main groups of epilepsy are recognized: partial and generalized. In partial epilepsies an abnormal neuronal discharge arises from a localized area of the brain, with a focus anywhere in the gray cortex or even in the adjacent gray matter; there may be single or multiple foci. Since the discharge may spread to other areas of the brain, symptoms of major or minor seizures characteristic of generalized epilepsy may occur which obscure the focal origin of the attack, but its focal nature is apparent from the presence of a warning symptom, such as an aura-like abdominal discomfort or a limb twitch, that precedes the disturbance of consciousness and corresponds to the site of the initial abnormal discharge.

A third of all cases of epilepsy in adults, and 20% in children, are temporal-lobe forms of partial epilepsy. Generalized seizures are characterized by synchronous and symmetrical discharges through both sides of the cerebral cortex. They are called either central or centrencephalic because there is electroencephalographic evidence of local initiating discharge in the subcortical, deep, central areas of the brain which spreads through both hemispheres. A characteristic feature of generalized epilepsies is a sudden disturbance of consciousness; in the major or grand mal type of seizure there is complete loss of consciousness with diffuse and symmetrical movements of the entire body. More commonly the seizures are of the petit mal type. The term petit mal, once used to describe all minor seizures, is now confined to brief episodes of sudden suspension of mental function and interruption of consciousness accompanied by a particular kind of brain-wave pattern, though other varieties may occur. Whether the type is major or minor in generalized epilepsies, loss of consciousness is sudden and not preceded by any warning symptom. Heredity seems more important in the generalized epilepsies than in the partial forms. Since a seizure can be produced in any child with a sufficient stimulus such as hypoglycemia or electro-convulsive therapy, it is seen that the potentialities for seizures exist in all brains. The genetic factor may be a predisposition with a lowered "threshold of excitability" in which brain cells in one person would be sensitive to neuronal discharges to which others fail to respond.

The school doctor not only needs to be aware of the new classification of epilepsies but also must recognize the wide variety of symptoms, including abnormal or delinquent behavior, that might be epileptic in origin. He needs to make a full clinical examination and note full details concerning the nature, frequency, and age of onset

of seizures as well as clues from the past history of the child and his family. Hospital X-ray and EEG tests may follow for confirmation of the initial diagnosis, although reluctance to label the child as epileptic may account for the fact that many persons are not referred for consultant or hospital service. Although the EEG is helpful, its limitations are such that it is not used as the one method of special investigation (183).

Except in cases of severe subnormality, ascertainment of the nature and extent of mental handicap in the child is an especially troublesome problem. Some parents are reluctant to admit even to themselves that their child may be mentally handicapped by bringing him to the attention of the proper authorities. Some are genuinely unaware that their child is subnormal, for in many instances inability to achieve in school is the first indication of mental retardation. This explains why the term educationally subnormal is so appropriate.

Teachers are therefore usually the first to suspect that limited mental capacity may be the child's problem, and to refer him to the school medical officer for examination. However, some teachers are reluctant to report a child. They may think the child is only "slow" and consider it a possible reflection on themselves to report him. They may even genuinely believe that they are as capable of teaching him as the staff in a special school. Some fear the social consequences for the child of segregation in a special school. In the recent past, some doctors as well as teachers have seen no point in formally classifying a child as educationally subnormal unless there was a reasonable chance of his getting the special educational treatment he needed. A few years ago an observer commented:

In an area where provision is known to be inadequate and the likelihood of action remote, Head Teachers are tempted to become cynical and refrain from referral on the grounds that it is useless 'for nothing ever happens.' Yet that is simply to perpetuate the vicious circle, and it can only be broken when the full extent of the hidden need is made plain (39).

Times have changed, partly through the realization that a local education authority cannot make adequate provision without first knowing the size of the group to be provided for, and early detection—preferably by age 7 or 8—makes possible better planning of the educational program for the mentally retarded child. The need for early assessment is now being met in part by some local education authorities who give group tests of achievement or intelligence soon after admission to a junior school at age seven, preferably using a non-verbal test so that children scoring below a certain point can be referred for more complete medical and educational assessment (183). The very size of the mentally handicapped group means that the problems of ascertaining different levels of intelligence and mak-

ing special provisions for them are commensurately greater than those problems associated with different types and degrees of physical difficulty.

Ascertainment means first a distinction between the normal child attending regular schools and the educationally subnormal who are capable of benefiting from education but who need some kind of special educational treatment; it means second a distinction between the educationally subnormal receiving some kind of education, and the mentally subnormal judged incapable of benefiting from education in school, and for whom training centers are provided.

Although neither the educationally subnormal (the ESN) nor the mentally subnormal are defined strictly in terms of IQ, actual practice has at times tended to define the mentally subnormal as an IQ range below 50 or 60, the ESN from 50 or 60 to 70 or 75,* and the backward or slow-learning "D-stream" † youngster from about 75 to 85. This was not the specific intent of the Ministry of Education 1953 regulations, which defined educationally subnormal pupils as "pupils who by reason of limited ability or other conditions resulting in educational retardation, require some specialized form of education wholly or partly in substitute for the education normally given in ordinary schools" (188). An earlier Ministry pamphlet (173) had suggested that the ESN pupil is one whose attainments are less than 80% of the normal for his age; this includes all dull children whose IQ's are less than 80, and also any other children of whatever grade of intelligence whose attainments are seriously below their age level. Compared with the position before the Education Act, 1944, the educationally subnormal now include the following groups (39):

1. Those with IQ's between 50 and 70, who before 1944 were classed as "educable feeble-minded" and could have attended special schools for the mentally deficient.
2. Dull children with IQ's between 70 and 80.
3. Those of any IQ whose attainments are lower than 80% of their age.

Categories (2) and (3) are new in comparison with pre-1944 provisions. Although there is still some tendency to think in terms of the first category alone, increasing emphasis on the multiplicity of factors accounting for low educational achievements has led to decreased stress on the IQ and therefore the inclusion of a wider range of IQ's in the educationally subnormal group.

Everywhere there appears to have been a shift away from what might be called the 'statistically conceived' child, to what might be called a longitudinal approach or developmental approach to each individual (346).

* The National Union of Teachers recommends that the IQ range for ESN pupils be from 50 to 70, with provision for children with IQ's over 70 only in certain circumstances (270).

† This term is used to denote a homogeneous grouping of pupils on the basis of IQ scores.

Another indication of a tendency to move away from the use of the term "educationally subnormal" and to use another term that includes a larger group is found in the Cheshire Education Committee's recent publication on "The Education of Dull Children at the Secondary Stage" (31). They define dull children as those in the IQ range of 55 to 85, but they also stress that the term "dull" should not be confused with the term "backward." They consider dullness to imply an inherently poor intelligence, whereas backwardness indicates a lack of educational attainment in one or more subjects, such as English or arithmetic. Since a child of any level of ability can be backward, a dull child may be merely dull or both dull and backward.

The children identified by the Education Act, 1944, as "incapable of receiving education in School" were primarily those with unmanageable behavior that was socially intolerable and disruptive for the rest of the class. It was not surprising that psychotic symptoms were confused with those arising from other conditions. The unmanageable children included those with primary amentia, temporal-lobe epilepsy, severe emotional disturbance, psychosis, and brain damage following trauma or encephalitis. Impulsive and hyperkinetic behavior, with mental retardation, might characterize any of these, and psychosis and brain damage might both involve abnormal perception and emotional disturbance (183).

On November 1, 1960, Section II of the 1959 Mental Health Act (164) came into operation, and introduced some changes in the law relating to children who, because of a "disability of mind," were considered, in the old terminology, incapable of receiving education at school. Among the changes were the following:

1. The expression "unsuitable for education in school," replaces the phrase "incapable of receiving education in school." This is in line with the recommendation of the Royal Commission on Mental Health (277) that no children should be labeled "ineducable." "Education in school" means, as before, education in ordinary schools, in special schools, or by instruction at home.
2. A local education authority may authorize any of its officers (medical or educational) to serve notice in writing, requiring a parent to submit a child for medical examination. This replaces the more time-consuming committee decision previously specified. The designated officer preferably is not the doctor who will give the examination.
3. The local education authority is now required, when informing parents of the proposal to report their child to the local health authority which has jurisdiction when the child is considered unsuitable for education in school, to acquaint them also with the functions of the health authority and the arrangements

made by that authority for the care and training of the child. This is usually done in a personal interview.

Another important change in policy is indicated by making the recommendation of a child for a special school an educational decision primarily rather than a medical one. Prior to 1944 the medical officer, by the very act of certifying a child, made the decision that he should attend a special school. But the 1944 Act made it clear that the decision must now be made by the local education authority, with the recommendation of the medical officer considered as advice to aid in such a decision. The authority is also expected to base its decision on reports and information from the child's teachers. Although there are still situations where the advice of the medical officer is regarded as final, it is considered desirable that the admission of an ESN child to a special school be based on a recommendation from a panel including the school medical officer, the chief education officer, an educational psychologist (school psychologist), and the head teacher of the present school and/or the proposed school (304).

The need for close cooperation between local education and health authorities was emphasized in a joint circular issued by the Department of Education and Science and the Ministry of Health in March 1966, which called for greater coordination among education, health, and welfare services for handicapped children and young people.

Their review of reports and surveys led them to the conclusion that:

While individual services for handicapped children and young people may be good, they are often not adequately co-ordinated. This frequently results in the handicapped, and particularly those who have more than one handicap, being deprived of beneficial services and continuous care, and in their families receiving inadequate support (57).

All local authorities were requested to review current practices with the end of achieving the following objectives:

1. Early detection and complete diagnosis of physical and mental handicaps, taking into account all apparent or suspected health disabilities, and assessment of practical measures for dealing with the handicap.
2. Regular review of medical, educational, and social factors to make possible optimum service to the child and his family, with eventual consideration of employment prospects and adult welfare services.

The circular continued:

Whilst ascertainment will often be made by the local authority health services, clinical responsibility will remain throughout with the general practitioner and the hospital specialist. Within the local authority, the health department

will have primary responsibility for children in the pre-school period, will retain it for those who are found to be unsuitable for education at school and will resume it in the case of many educationally sub-normal or maladjusted children who find difficulty in adjusting to adult life after school. The education department, including the education authority's school health service, will be primarily responsible during the school years, in certain cases from the age of two years, and perhaps after leaving school if a substantial amount of further education is provided. . . . The responsibilities of each of these services in relation to children with various single handicaps or with multiple handicaps need jointly to be examined and agreement reached about the services to be made available.

Another important suggestion in the circular was that the staff member—the mental health worker in the case of the severely mentally retarded—be given general oversight of the child from an early age. Local authorities were invited to submit information by September 30, 1966, concerning the changes made to secure better coordination. This closer coordination would have the additional effect of minimizing legal formalities that might frighten or further distress parents who are already upset by the fact that their child has been designated as very backward. The very division in responsibility between the education and health authorities for children with different IQ levels creates what many educators feel to be an unnecessary and arbitrary gap between two groups of children, which accentuates parental feelings of dismay when their child is classified in the lower group. Under existing conditions the best that can be done is to see that there is a smooth transition of responsibility from the education to the health authority.

Parents may appeal to the Minister of Education against the following types of decision made by the local education authority:

1. That their child should be classified as a handicapped pupil (though as indicated above, no appeals of this kind are as yet on record).
2. That their child should be classified as unsuitable for education in school rather than as educationally subnormal.
3. That their child should be sent to a particular school.
4. That their child cannot withdraw from a particular special school.

When parents appeal against a local education authority decision that their child be classified as unsuitable for education in school, they must do so within three weeks of receiving notice of the education authority's intention to report their child to the local health

authority. They may also request the local education authority to review the decision, but no earlier than a year after the decision was made and no oftener than once in each succeeding year. If the classification remains the same, the parents may again appeal to the Minister of Education. Parents also have the right of appeal in cases when they object to a particular school chosen by the local education authority, or when this authority refuses to allow a handicapped pupil to be withdrawn from a particular school. The last type of case involves educationally subnormal children who reach the age of 15. If the child attends an ordinary school he is not subject to compulsory attendance past the end of the term in which he becomes 15, but in the special school he must stay till age 16, a practice which some parents regard as discriminating against rather than helping the handicapped child (183).

In instances where parents appeal the decision to classify their child as unsuitable for education in school; the Minister will always decide, where doubt exists regarding the accuracy of the ascertainment, that the child should be given a trial period of special education, or a further trial period if he has already had one. The greater difficulty in ascertaining the need for special educational treatment of younger children when compared with older children is shown by the percentages of appeals upheld in a ten-year period from 1951 to 1960 inclusive. These percentages of cases in which decisions were successfully appealed were much higher for younger children: 46% for children 5 to 7; 32% for children 8 to 10; and 22% for children 11 and over (183).

The new arrangements make possible a periodic review of the progress of children found unsuitable for education in school. The possibility of cancelling the earlier decision, if the child's progress warrants this, provides greater flexibility. Parents continue to avail themselves of the opportunity to appeal a decision of the local education authority when, after such a review, their child is still classified as unsuitable for education in school. From 1960 to 1962, 184 decisions had been cancelled under these arrangements; 17 cases were referred to the Minister of Education on appeal. During 1963, 176 reviews were carried out by local education authorities, and 78 decisions cancelled, with three appeals being made to the Minister (176).

Medical officers who make an initial judgment concerning the mentally handicapped child must have some special training for this purpose. The Medical Examinations (Sub-normal Children) Regulations, 1959, make it obligatory for medical officers who undertake the assessment of educationally subnormal children to attend at least one of certain approved courses of instruction. For more than 20 years prior to 1959, the only course of instruction available was one provided by the Department of Extra-Mural Studies at the University

of London which was organized chiefly by the National Association for Mental Health. More recently courses have been provided by the Universities of Durham and Bristol. These courses last for three weeks, and include lectures and demonstrations concerning mental and educational subnormality as well as instruction and experience in mental testing. It is important, though difficult, to include in this brief course some reference to the emotional needs and problems of children. The number of applications for such courses has increased to such an extent that some school doctors have had to wait two or three years for this instruction; the heaviest demand has fallen on the London course, which provides instruction for about 40 doctors in one session. For many years the Joint Committee there organized two courses a year, and sometimes three. It has also organized a refresher course every other year for doctors who qualified for the work many years previously (183).

The difficulties involved in arriving at an accurate diagnosis as to whether or not a child is unsuitable for education in school make it necessary for the school doctor to understand the sequence of child development and the many factors affecting it. His diagnosis requires some prediction as to the youngster's eventual social capacities as an adult, and a judgment as to how he might react to a special school as compared with a training center. This diagnosis is obviously easier to make in the case of older youngsters than younger ones, especially those below the age of 7 or 8. The doctor also faces the difficulty of defining "education." Definitions are as numerous and as subject to change in England as in the U. S., and the framers of the 1944 Act wisely forebore giving specifics which would have hindered more than they would have helped. There is an increasing tendency for teachers and school doctors alike to define education as something more than reading, writing, and arithmetic; they consider it to include physical, social, and emotional learning as well. This change in concept parallels the current practical emphasis on how best to integrate the handicapped youth into the community, and the research findings which reveal, for example, the complex causes of mental subnormality and the role played in the learning process by factors other than intelligence per se. Therefore the school doctor takes into account, when making a diagnosis, many other motivational and personality factors besides the IQ, for otherwise he might classify children as unsuitable for education in school solely on the basis of formal educational expectations (183).

After discussing in detail the many personal and social factors which may affect the development of inherent capacity, the government report "Health of the School Child 1960 & 1961" recommends thinking in terms of "border-zone" children rather than "border-line" children (183). Although an IQ score can furnish the school doctor with valuable clues concerning a particular child, he is advised

to interpret it in terms of IQ ranges rather than in terms of a point on the scale. The report further stresses that we must not regard mental subnormality as a final, fixed, irreversible level of functioning, but recognize the various emotional, physical, or cultural influences which affect it. This point of view is underscored by the number of papers given at the 1960 London Conference on the Scientific Study of Mental Deficiency which emphasized the exogenous, and sometimes remediable, factors helping to determine mental deficiency before, during, or after birth (307).

It is the responsibility of the principal school medical officer to determine whether a school doctor is suitably qualified to undertake intelligence testing for the assessment of the educationally subnormal, provided that the doctor has assisted a qualified medical practitioner in giving this kind of examination for a period of at least six months. It is interesting to note that in English practice it is the school doctor who administers intelligence tests rather than a school psychologist, who is called an "educational psychologist" in England. Few medical officers claim to be as well qualified to administer intelligence tests as educational psychologists, but there are still not enough of the latter to meet local authority needs (183).

The Terman-Merrill (Stanford-Binet) is still considered the most suitable test for school doctors to use (as also specified in New York state law for determining the educable and trainable mentally retarded who need special classes), even though this test might penalize children with a speech defect or language difficulty, or those who had never been to school or who came from a poor cultural background. Some adaptations are found necessary to make the test meaningful to English children. Before the Mental Health Act, 1959, it was mandatory to use the Terman-Merrill intelligence test, but it is now optional, although most doctors and educational psychologists continue to use it. Since there is controversy in comparing results from the Wechsler and Binet tests, and since differences in scoring of just a few points could determine whether a child would be placed in a school situation or in a training center, most experts believe it would be much better to use more than one intelligence test for such classification.

Intelligence test results, however, are not the sole basis for assigning a child to a special school for the educationally subnormal, as shown by the fact that in a 1956 survey a third of the children in such schools had IQ's of 70 or over, and nearly 5% had IQ's of 80 or more. Although there is a tendency for the average IQ's in the special schools for the educationally subnormal to increase, the Ministry of Education has reaffirmed the basic principle that such schools are intended first of all to serve children whose educational retardation is associated with an appreciable degree of mental subnormality.

There is great need for additional places in ordinary schools for ESN children who require only part-time special help. English educators believe there is danger that the school doctor may make recommendations based on the facilities available instead of on the actual needs of the child. The very fact that so many youngsters in the ESN schools have IQ's above 70 indicates that more places are needed for these children in the regular schools.

It is expected that as education is defined more broadly and more special school places become available for the educationally subnormal child, young children of school age will not be ascertained as unsuitable for education in school, except in the most obvious cases, without first having had a trial period in school under favorable conditions. It is recommended that this trial period last about a year, and that it occur routinely rather than merely as a result of a parent's appeal to the Minister of Education. Such a recommendation is endorsed by the National Union of Teachers, which stresses the desirability of assessment units with educational psychologist services for youngsters with IQ's under 50 attached to special schools, with smaller classes and larger staffs, proportionately, than the special school itself (270).

The important goal is to place the ESN child in a special school early enough to benefit from continuity in such a program. Although some youngsters are placed in ESN schools as late as the age of 13 or 14—when for example they are first “discovered” at the time of the secondary selection examination or when they enter a secondary modern school—the practice is not considered wise. One writer points out that placement should occur neither too early nor too late, and recommends that the child be placed in the special school no earlier than seven years of age and not later than nine or ten (39).

Current developments suggest the likelihood that the present sharp distinction between the educable and trainable groups will eventually be eliminated. Meanwhile each year the largest increase in special-education places in England occurs for the educationally subnormal, while continuing efforts are made to increase the number of training centers for the mentally subnormal, and to improve the quality of experiences provided in them.

Special Education as a Whole

Whatever the nature of the handicap a child brings with him to a program of special educational treatment, the broad purposes of this program are identical: (1) appropriate medical and educational treatment which are needed to help the child to discover, and achieve maximum use of, his physical and mental capacities; (2) the resultant development of physical and emotional independence, and maximum self-help with a minimum of self-pity and demands for

special attention: (3) the development of self-understanding and self-acceptance, with a sense of personal worth; (4) the development of socially acceptable behavior, including attention to personal habits of cleanliness and good grooming, which make possible more ready acceptance by the non-handicapped in work situations, community life, and personal encounters; (5) the cultivation of a variety of leisure-time skills and interests for the enrichment of the youngster's entire life; (6) the simultaneous widening of horizons by providing supplementary recreational and holiday experiences in artistic and cultural pursuits, sports and games, camp life, and periods at holiday hotels; and (7) aid in selecting a future vocation or profession based on a preliminary assessment of interest and abilities.

Special education is available in a variety of contexts: (1) regular classes in ordinary schools; (2) special classes in ordinary schools; (3) day special schools; (4) residential special schools, though these at times have some day pupils as well; (5) hospital classes, or individual instruction in the hospital where there are not enough youngsters to form classes for their instruction; (6) home instruction for those temporarily or permanently unable to attend special or regular classes or schools; and (7) some further education and higher education in programs provided for youth in general.

There are at present 760 maintained (publicly established and supported) special schools providing for approximately 65,000 pupils including over 3,000 in schools in hospitals for children receiving medical treatment as in-patients. About two-thirds of these maintained special schools are day schools, but for children with severe handicaps whose needs cannot be met in day schools, or who live too far away from a day school, free education in a residential school is made available. There are also 122 non-maintained private special schools, chiefly residential, providing for about 9,000 handicapped pupils whose fees are paid in full by local education authorities. In addition to school provisions, nearly 5,000 children are being educated by local authorities in their own homes or in small groups. (56).

A major program of expansion of special-school places was announced in 1964. The projects on which work was to start during the next two and one-half years were to provide 8,000 new special-school places, including 6,600 for ESN children and nearly 900 for maladjusted children. In all, 75 new schools were to be built, 10 major extensions were to be carried out, 17 schools were to be provided with enlarged plants, and 31 others were either to be replaced or substantially improved. The total cost of £10.66 million was divided as follows: £7.37 million for new special-school places, £3.06 million for replacements and improvements, and the remaining £230,000 for clinics. The plans took shape with the beginning of the building of 34 major special school projects in 1964, with a total

value of £3.2 million, and the completion of 52 other projects valued at £4.7 million (177). At the end of 1965, 52 projects valued at £5.1 million were under construction (53).

The school-leaving age is higher for the handicapped youngster unless he attends a regular school. In special schools attendance is compulsory till age 16 in contrast to age 15 for all youngsters in regular schools, but at some schools, including two or three special grammar schools, young people stay till the age of 18 or 19. There are a number of training establishments for the blind and physically handicapped in which general education and vocational training are combined to some extent. Education is free in special schools as in other government schools. Local education authorities are empowered to give maintenance allowances to pupils over compulsory school age who stay on in school for full-time education, this allowance being determined on the basis of the family's rating on an income scale drawn up by the authority (178).

In considering the implications of raising the school-leaving age to 16 for all youth by 1970, the Working Party of the British Council for Rehabilitation recommended that the present school-leaving age of 16 specified for handicapped pupils in special schools should not be raised. However, in certain cases where further assessment of potentiality seems desirable or the record of accomplishment is clear, the parents should be encouraged to persuade their handicapped children to remain in school voluntarily beyond the age of 16 (10). The handicapped youngster attending a regular school would benefit from the extension of the school-leaving age probably even more than his normal classmates, since maturity and length of schooling are such critical factors in his job placement. Modifications of existing curricula to provide more varied types of programs with special appeal for older adolescents would also be of advantage to the handicapped, since a large proportion of them are not suited to the academic courses that have tended to dominate the upper years of English secondary education (13, 275).

The obligation of the local education authority to make adequate provisions for the education of the handicapped does not end with the organization of the special-education program itself. The local authority is also obligated to make whatever supplementary arrangements may be needed to enable the handicapped youngster to take advantage of such a program. For this reason other auxiliary services may be required. Many communities provide special transportation when handicapped youngsters attend day schools, as in London where the County Council operates a fleet of buses for this purpose, many of them being specially modified for equipment such as wheelchairs and litters. Some children of primary-school age in London are escorted to and from school by "guides," whereas other youngsters find it possible to travel alone on public transportation, par-

ticularly the educationally subnormal and delicate of secondary-school age (153).

The curriculum of special schools is a form of general education rather than vocational training. Although some of the courses offered appear to be vocational in nature, a distinction is made between that training which is considered important as part of the general development of the pupil, and training which is designed specifically as preparation for the world of work, as provided in further-education programs and in job-related training. As one example, house-craft is taught to a variety of physically and mentally handicapped children on the secondary level as part of their general education rather than as preparation for domestic service, or even strictly as training in muscular coordination (58).

Repeatedly during the years since the Education Act, 1944, there has been emphasis on the need for considering special education as a part of general education, and for integrating the handicapped child in programs for non-handicapped children wherever possible. An example is an effective statement made by the Chief Medical Officer of the Ministry of Education in 1954:

For the handicapped child the normal field of opportunity should be open to the fullest extent compatible with the nature and extent of his disability. The fact that he has a mental or physical handicap does not necessarily involve his withdrawal from a normal environment but, if he has to be withdrawn at all, the withdrawal should not be further or greater than his condition demands. Handicapped children have a deep longing to achieve as much independence as possible within the normal community instead of being surrounded by an atmosphere of disability, but their handicap carries with it, especially in older children, a danger of psychological and emotional disturbance, resulting from a sense of deprivation and frustration. This can often be countered by retaining them within the normal environment, or as much of it as their condition allows, provided that within it they are treated with understanding and given the fullest opportunities (317).

This philosophy was stressed ten years later in the report given by the National Association for Mental Health to the Plowden Committee then preparing its report on primary education (165). It is still recognized, of course, that the needs of many individual handicapped children continue to be met best in the special school.

The acceptance of the philosophy of integration thus means the inclusion of the handicapped child wherever possible in regular school programs, and even when attendance at special schools is necessary, it means preparation of the youngster for life as a self-sufficient adult in the normal community. Handicapped children

are recommended for a special school only when they cannot be taught properly in a normal school or when their presence would be disturbing to other children as in some cases of epilepsy. Day schooling is still considered impossible in the case of some handicaps like total blindness. Even in a densely populated country like England there are some areas where the number of blind children is too small to make up a special school, and therefore these children are educated in residential schools (7). No experiments with including blind children in regular elementary schools have so far been undertaken as in various parts of the United States.

The increased emphasis on integration of the handicapped youngster into the regular school is reflected by parent demands that their child receive this kind of treatment. For example, a deputation of parents of thalidomide babies, when they approached the then Minister of Education, Sir Edward Doyle, demanded and were assured by the Minister that wherever possible their children would be educated in ordinary schools. But integration as a general policy does not eliminate the need for special schools. Such schools will always be needed for some children, and it may prove that thalidomide babies have special needs that can usually be provided for better in special schools than in regular schools.

Effective integration on the secondary level, however, is more difficult to achieve than on the elementary level, as Professor Tizard has pointed out in a recent article:

While we know a great deal about the kind of special educational treatment which will benefit the *young* handicapped child—it should, wherever possible, be home-based and associated with an ordinary school and with teachers who understand and apply the basic principles of child development—we are much less well placed today to meet the educational and social needs of handicapped children in the older age groups. The main reason for this is the appalling inadequacy of the present secondary school provision as a whole, coupled with its rigidity and competitiveness (373).

The comprehensive school, closer in organization to the American secondary school than the grammar school, should be best able to make provision for the handicapped adolescent because of its size and the range of subjects it is able to teach. For example, technical drawing, metalwork, and other prevocational courses are most likely to be available in the comprehensive school, where there is less emphasis on purely academic learning and preparation for selective examinations.

Another trend is to decrease specialization in the assignment of pupils with certain kinds of disability to special schools, for it has been observed that over-specialization leads to rigidity of classification and the exclusion of children who do not fall within a narrowly

defined group. The educational needs of children with different handicaps tend to be the same, and their medical and para-medical needs can be met by a parallel program of appropriate individual treatment. Children with cardiac problems and others with mild forms of cerebral palsy, for example, can be taught in the same classroom by the same teacher while receiving different therapeutic programs. Too frequently, as in the United States, vigorous parental efforts to insure proper care for their children have led to the establishment of special programs for specific groups like the cerebral palsied. Neat organizational patterns, fund-raising requirements, and even sometimes the vested interests of long-term officers of voluntary societies, and staff members of special schools, are gradually giving way to a recognition of the needs of handicapped children in general. This reflects the awareness that the handicapped child is first of all a child with the same needs as other children, and only secondarily a child who needs special treatment and facilities to enable him to reach his full potential development.

This move toward integration rather than increased specialization of interest in handicapped groups is illustrated by the announcement in the autumn 1965 issue of *Special Education* that this issue represented an amalgamation with *Spastics' Quarterly*, the educational journal of the Spastics Society. *Special Education*, which first appeared as the journal of the National Special Schools Union in 1904, was the first publication concerned with the educational aspects of physical and mental handicaps. *Spastics' Quarterly*, first published in 1952 by the British Council for the Welfare of Spastics, was the first national journal in the United Kingdom to provide general information on cerebral palsy at various levels of professional interest. When the National Spastics Society began to publish *Developmental Medicine and Child Neurology* in 1962, the earlier spastics publication changed its role to that of providing material dealing with social, welfare, and educational aspects of cerebral palsy. When the two organizations serving the cerebral palsied united in 1963 as the Spastics Society, it was felt that this new society should have a journal covering a wider field, recognizing that the problems of spastics must be seen against the background of many associated types of handicap and of normal child development. It became evident that in this new light *Spastics' Quarterly* and *Special Education* were serving the same functions and could best perform these functions by merging.*

Among the findings of continuing research to improve the curriculum and methods of special education, programmed learning is seen to play a role of increasing importance:

The position of programmed learning seems established as a teaching tool by a skillful teacher to improve his range

* Editorial, *Special Education*, Autumn, 1965.

of contacts with individuals, to give the necessary amount of practice in skills and concept formation and to provide additional variety in the teacher's armory of methods (143).

New developments reveal an increasing range of materials suitable for inclusion in programs, with more possibilities for using concrete materials and group work projects.

The special teacher, who plays the crucial role in the education of handicapped children, is better selected and better prepared than ever before. One reason is that the role of such a teacher is better understood; for instance, the role of the teacher in residential special schools is different from that of teachers in boarding schools for normal children. Such a teacher needs to be able and willing to identify himself more continuously and intimately with handicapped children than would be true if he were teaching in a regular school. In the special school extracurricular activities are an even more integral part of the child's education and adjustment to life, and the teacher cannot remain detached and aloof since this school is after all by definition a treatment center. The teacher's schedule is further complicated by the fact that the difference between formal and informal education is not so clearly marked in special schools as in schools for normal children, and so educational activities are not confined to specified daytime hours. A teacher's services in refereeing a football match for deaf boys is to be regarded as skilled in exactly the same way as if he were giving formal classroom instructions. Since the teacher in the residential special school works longer hours than the teacher in a day school, the National Union of Teachers recommends that their rates of pay be equalized and the total residential work load limited (271).

Although there were special schools in existence before 1900, most specialized training for the teachers in these schools did not develop until the 1950's. The earliest programs of special training were organized for teachers of the blind and of the deaf in 1908, and these are still the only groups (including the partially hearing) for whom such training is mandatory. Increasing emphasis is being given, however, to the importance of taking advantage of the programs currently available in special education (131).

One characteristic of teacher preparation is the increasing tendency to include a common core of information about handicaps in general, in addition to courses about a specific handicap, in view of the effort to avoid a high degree of specialization in the instruction for children with one type of handicap. The need for a wider range of information is underscored by the increasing numbers of multiply handicapped children in special schools who are enabled to survive as a result of improvements in living standards and medical care. For instance, in the refresher courses and conferences for home teachers of the blind held in 1962 by the Regional Association for

the Blind, the emphasis was on widening their knowledge of disabilities other than blindness (200).

Experience in teaching normal children is considered a desirable part of the background of special teachers, and most of them have had some experience of this kind. However, programs of training for special teachers have no common requirement as to the nature or extent of previous teaching experience. Except for the Manchester University course for teaching deaf children, which may be taken immediately following a course of initial training, requirements vary from "some experience" to "at least five years." There is also variation in the type of teaching experience required, for it may be in regular schools, in special schools, or simply "approved teaching experience" (131).

Another characteristic of special educational provisions is the increasing emphasis now given to opportunities for further education for handicapped youth beyond the secondary level, as distinct from specialized vocational training. Further education is simply defined as post-secondary education, but the term usually does not include higher education, this title commonly being reserved for university studies. Further education in most cases applies to a kind of technical education which is closely related to the world of work, of industry and commerce (7). The line to be drawn between technical education and technical training is not always easy to determine. In general, the preparation received in technical and county colleges is considered to be *education* whereas that received in industry or in places designated as training centers is considered to be *training* since it is less academic and more specifically vocational in nature.

Further education can take three forms: (1) evening classes one, two, or three nights a week combined with a full-time job; (2) one day off a week for study ("day release" courses), allowed by the employer in a full-time job; (3) one day off a week for study, on the employer's time, plus evening classes on the employee's own time (7). The courses are provided by both statutory and voluntary groups in technical and commercial colleges, art colleges and schools, in agricultural and evening institutes, and can be entered at any age from 16 on by young people and adults who have left school. Further education is not free, but the fees are low and often nominal for young people under 18, and local education authorities frequently make grants to help students with the cost of their courses and maintenance (178).^{*} Some special schools, particularly those for the physically handicapped and the blind, provide further education themselves, along with pre-vocational training and assessment for employment (56).

^{*} A full discussion of the kinds of technical education provided, places where given, financial aid available, and requirements for the training is found in "Technical Education in Britain," a 1962 HMSO publication (28). A detailed discussion of secondary and further education, and survey results concerning school leavers in general, can be found in the Crowther report "15 to 18" (180).

Further education may also be provided as part of the hospital-school program, either through direct instruction or by means of aid with correspondence courses. A pioneer in such offerings was the Royal National Orthopaedic Hospital School in Stanmore. In 1952, the Middlesex Education Committee for the area in which the hospital is located approved a proposal for providing instruction, chiefly in commercial subjects, for patients above the normal school-leaving age. The program was steadily expanded to include work in languages and other advanced courses. In 1963-64, of a total of 68 persons taking commercial subjects, 28 were in the age range of 16 to 21, and 19 were under 16 years of age. A typical example is the case of Ann Cook:

Ann, who was severely disabled by polio at the age of three, spent three years in hospital, had all her primary education either in this hospital or at home with a visiting teacher, and passed her selection examination for the Walpole Grammar School, Ealing. . . . She had been provisionally accepted at Exeter University subject to a degree of mobility ensuring independence. In consequence at the age of nineteen Ann was readmitted here for general assessment in October 1963. She needed help in walking and climbing steps, aids to hip flexion and strengthening of her arms. During her time here she had a full programme of physiotherapy, occupational therapy and driving lessons. In addition she started a course of Shorthand and Typing, making such good progress that she was able to enter for Stage I Examinations of the Royal Society of Arts in these subjects at Whitsun 1964, passing both with credit. In July 1964 she passed the Shorthand-Typist's Certificate Examination of the Royal Society of Arts with distinction, an outstanding achievement in the time available.

When it became apparent that sufficient progress was not being made physically for conditions at Exeter, Ann applied to Reading University and was accepted unconditionally. She is now studying for a degree in Sociology, has joined several societies and is able to be fairly independent. In a letter to Miss Turner, Ann says — "Please circulate the news that everything is going marvelously here. I can never cease to wonder how quickly time passes — it seems only yesterday that I arrived at Stanmore to begin the 'long road' that finally led here. I can never thank you all enough for your efforts" (336).

An expansion of further-education opportunities for handicapped youth is needed. One problem is that because of the limitations occasioned by their disabilities, many handicapped youngsters leave school

with an education less adequate than that of other children, and therefore are less well prepared to enter existing programs of further education, even though they need such programs more than do normal youth for this very reason (10).

Another problem is that the waiting period for further education may be anywhere from 12 months to two years. The alternative is the seeking of employment through the youth employment officer, even though the youth may not really be ready for full-time employment. The actual dimensions of the problem are unknown because handicapped youngsters, like the non-handicapped, are not required to seek his services (95).

A new approach to technical education for both handicapped and normal youth was recommended in the White Paper on "Better Opportunities in Technical Education." Here it was pointed out that evening classes have serious limitations as the only method of vocational education for boys and girls in full-time employment. Many evening institutes have now expanded their vocational curricula to include non-vocational and recreational courses open to adults of all ages.

Another suggestion concerning arrangements for further education and training of the handicapped was made by a government committee which recommended the establishment of a single institution devoted to the purpose of providing further education and training solely for physically handicapped youngsters of both sexes for the period between leaving school and finding employment.

This institution should be able to provide a broad general education and give students some introduction to vocational training. When such an institution has been provided . . . the status and function of the other establishments should be reviewed (175).

Aside from further education, there is an awareness of the need for more opportunities for university education. So far relatively few handicapped youth have obtained university degrees. At the same time, it should be recognized that proportionately few youth in England, as compared with the United States, continue with post-secondary education. A recent government report indicates that in 1962-63 only about 13% of all boys reaching the statutory school-leaving age, and about 16% of the girls, entered the universities, colleges of education, or other full-time further-education programs. It was assumed that the remaining 87% of the boys and 84% of the girls had entered employment (56).

At present the only groups of handicapped children whose teachers must have special training are the blind, deaf, and partially hearing. To qualify as a permanent teacher of the blind the candidate must first be a qualified teacher, and then must have (1) successfully completed a one-year course in the teaching of the blind at Birmingham

University, or (2) passed an examination for the School Teacher's Diploma of the College of Teachers of the Blind, after serving a minimum of 18 months and a maximum of three years in an approved school for the blind. Because of the increasing numbers of the multiply handicapped blind, course material related to other forms of handicap is now being included in the training program, particularly regarding the deaf-blind, with whom teachers must be able to converse by a special manual method (364).

Candidates seeking to qualify as teachers of the deaf or partially hearing must first obtain a university degree or a teacher's certificate, followed by one of four possible programs of training: (1) a one-year course at Manchester University leading to the University Certificate for Teachers of the Deaf; (2) a one-year course at University College, Dublin, leading to the University Diploma for Teachers of the Deaf; (3) a one-year course at the University of London Institute of Education, which began in October 1965 (53), leading to the Institute's Diploma in Education of the Deaf and Partially Hearing; (4) taking an examination to obtain the Teacher's Diploma of the National College of Teachers of the Deaf after part-time study while teaching in a school for the deaf or partially hearing. This examination may be taken after a period of from 18 months to three years of service in a recognized special school for these groups. Teachers of special classes for the partially hearing in regular schools must also meet one of the above requirements.

Although special training is not mandatory for teaching other groups of handicapped children, many teachers take advantage of programs currently available, such as a one-year course offered in many colleges and universities for teaching the ESN child, a new course of training specifically for teachers of the physically handicapped established at the University of London in 1965, with special reference to the needs of the cerebral palsied, and a year's course at this university on the education of maladjusted children. The Department of Education and Science also provides occasional short courses in special teaching such as for the physically handicapped. Courses on handicapped children which are included in general teacher-preparation programs also include information on specific groups such as the physically handicapped, maladjusted, speech handicapped, and children with multiple handicaps (131). The total number of one-year courses for teachers of children requiring special education treatment rose in 1965-66 to 34, providing for a total of 415 students (53).

The new training courses at the University of London Institute of Education for special teachers of the physically handicapped and of the deaf and partially hearing supplement existing courses in child development and those for teachers of the educationally subnormal and maladjusted. It was also announced in July 1964 that a new

Chair in Child Development was being founded at this Institute with the aid of endowment from the Spastics Society; Professor Jack Tizard has been selected as the first person to occupy this chair. Training programs for special teachers thus continue to expand.

SPECIAL EDUCATION RELATED TO DIFFERENT DISABILITIES

There are some limitations to the figures currently available concerning handicapped children receiving special education, as an index of the total number of school-age children with handicaps:

1. The figures do not show regional variations.
2. They do not include *ineducable* or severely retarded children, so subnormal that they cannot be trained in school.
3. They do not include the over-16 group taking vocational courses under the jurisdiction of the Ministry of Labour.
4. They do not include the physically handicapped who are so well integrated into ordinary schools that they are no longer considered handicapped.
5. The figures may not be comparable to those of other countries because the preschool data are included in England and usually not in other countries.*

For physical handicaps other than blindness, there are no comprehensive national statistics. In April, 1962, 541,616 physically handicapped people (other than those with eye defects) were registered with the Ministry of Labour as "disabled persons." Ministry of Education statistics show that in January 1962 there were 30,000 children requiring special educational treatment on account of physical disabilities other than blindness or partial sight. These figures indicate that the numbers of handicapped people registered with local authorities cover only a small proportion of the total handicapped population. It is not suggested that every person with a hearing or crippling disability should or will seek welfare assistance through registration, but since in previous years local services have been very uneven with some local authorities having made no plans for such groups, it is clear that in the country as a whole the total number registered for services should increase substantially during the next ten years (200).

In January 1965 there were altogether 882 special schools, with 6,271 full-time teachers and 74,299 pupils, as compared with totals of 867 schools, 6,041 full-time teachers, and 72,541 pupils for the previous year. There were 13,195 children awaiting admission to special schools in January 1965, as compared with 13,395 in 1964;

* Report by James Lumsden at the Ninth World Congress of the International Society for Rehabilitation of the Disabled, June 1965.

of this total 9,932 were educationally subnormal and 1,177 were maladjusted (53).

The data provided in the 1963 list of special schools for handicapped pupils in England and Wales indicate the following numbers of such schools for the various categories of handicap.*

Special Schools

Category of Handicap	<i>Day</i> Secondary		<i>Boarding</i> Secondary		Size Range	Total
	Total	Only	Total	Only		
Blind	0	0	20	3	28-168 (5 over 100)	20
Partially sighted	29	0	9	0	80-300 (18 over 100)	38
Deaf and partially hearing	28	1	30	3	30-345 (31 over 100)	58
Educationally sub-normal	288	36	124	54	20-240 (257 over 100)	412
Epileptic	0	0	6	0	60-405 (1 over 88)	6
Maladjusted	15	1	47	17	12-150 (2 over 60)	62
Delicate	0	0	53	5	27-180 (18 over 100)	53
Physically handicapped .	0	0	49	8	10-300 (2 over 100)	49
Delicate and physically handicapped	132	3	0	0	12-270 (83 over 100)	132
Speech defect	0	0	2	0	24, 50	2
Multiple defects	0	0	6	0	12-88	6
						835

In addition, 95 hospital schools are listed, which provide in most instances for a variety of handicaps. The above list includes all day and boarding special schools approved by the Minister of Education up to July, 1963, but it does not include any Independent Schools which may take handicapped pupils. Two boarding homes, for delicate and for diabetic children, are not included in the above summary, nor are the five establishments for further education and training for the physically handicapped: St. Loyes College in Exeter, the Lord Mayor Treloar College in Froyle, the Derwen Cripples' Training College in Oswestry, Queen Elizabeth's Training College in Leatherhead, and the School of Stitchery and Lace for Crippled Girls in Great Bookham.

* The discrepancy between the figures taken from this list and those cited in *Education in 1965* may be due to additions in the two-years' interval, and a different basis for inclusion of particular establishments in the totals; for example, independent schools taking handicapped pupils are not included in the 1963 list.

Because of small numbers in Wales, two or more authorities usually cooperate to provide educational units for handicapped pupils. Since World War II two boarding establishments were specifically built for the handicapped; the first was Erw'r Delyn in Glamorgan, serving the south, and in September 1962 the new Gogarth special school for the physically handicapped opened at Llandudno, administered by six North Wales authorities. It was expected that the full complement of 60 pupils would be reached in 1963 (175).

Changes in incidence of certain kinds of disability are reflected in a decrease in provisions for the delicate and the physically handicapped (175). Also a growing proportion of the delicate and physically handicapped children suffer from double or multiple handicaps. Formerly the schools for delicate children included large numbers of youngsters with general debility who needed only a short period of residential care, under favorable physical conditions, to restore them to normal health, but such children now account for a much smaller percentage of the population in these schools. On the other hand, these schools now contain many children with a combination of handicaps, a situation which presents additional teaching problems. Such changes in the special school population make necessary continuous review and revision of the program of special educational treatment (176).

Blind

The blind are the group for whom the most accurate figures are available, as the numbers of blind persons on the registers of local authorities for those seeking welfare assistance comprise virtually all the blind (200). The following table indicates their numbers as compared with other categories of sensory handicap.

**Incidence of Those Registered With Sensory Defects
as of Dec. 31, 1961 (200)**

<i>Category</i>	<i>Total</i>	<i>Under 16</i>	<i>% of Total</i>	<i>16-64</i>	<i>% of Total</i>
Blind	96,591	2,246	2%	29,708	31%
Partially sighted	25,206	2,330	9%	7,518	21%
Deaf	22,906	2,444	11%	17,080	75%
Partially hearing	14,823	1,217	1%	6,753	46%
Totals	159,526	8,237	5%	61,059	38%

Blind pupils are "pupils who have no sight or whose sight is likely to become so defective that they require education by methods not involving the use of sight."

In January 1964 there were about 1,400 blind children requiring or receiving special education in special schools (131) or about 0.2 per thousand of the total number of school pupils (295). Of the total registered blind (112,000 in 1964 [334]), which includes both

younger and older age groups, it is estimated that 20% have other handicaps in addition to blindness (364), including 2,500 deaf-blind persons (199). The high proportion of children with more than one handicap in special schools for the blind (53) includes many who are so retarded mentally that their sense of touch is not good, with the result that the embossed Braille dot is not the boon it was in the past. The virtual elimination of infectious disease as a cause of blindness has resulted in schools for the blind being left with children whose blindness is due mainly to congenital conditions which often give rise to additional handicaps (183).

Blind children attend 23 special schools of which 19 are operated by voluntary groups with varying amounts of government subsidy. Only about 5% of blind children are day pupils, and these attend classes in residential schools. There is one teacher for every 8 pupils on the average. Even though regulations permit a maximum class size of 15, there are no oversize classes.

At the age of 2—or more commonly at age 4—the blind child may attend one of the Sunshine Homes for nursery-age blind children maintained by the Royal National Institute for the Blind. From here he may move on into a primary or all-age school. Secondary education, starting at age 11 or 12, is obtainable in a variety of schools: in secondary modern schools such as Henshaw's in Manchester; in grammar schools for brighter youngsters, one for boys at Worcester and one for girls at Chorleywood; and in the Royal Normal College and Academy of Music at Shrewsbury which provides education for selected pupils up to age 20 or 21 with specialization after the age of 16 in music, piano tuning, or shorthand and typing (131, 218).

A secondary modern school for blind youngsters with other handicaps is Condoover Hall School at Condoover near Shrewsbury. A small unit for deaf-blind children was opened in 1952 to meet a need not being met elsewhere; it occupies separate premises adjoining the main school. In such secondary modern schools for the blind, there is in addition to a normal curriculum a full program of handwork: besides pottery making for both sexes, there is for the boys woodwork and basket work, and for the girls, housecraft, knitting, simple sewing, and light basketry. Both boys and girls are taught type-writing up to the age of 13 if they are reasonably competent in Braille, for this skill will provide an important form of communication in post-school years. Throughout these secondary-school years the blind youngster is helped to gain confidence in facing a future in the sighted world by means of developing leisure-time interests, acting, visiting the public swimming pool, visiting the cinema or theatre or concert hall, and mixing with sighted youngsters in Scout-ing and Guiding activities (329).

Pupils leaving special schools for the blind at age 16 may be as-

sessed and trained at establishments approved by the Minister of Education which provide vocational training and education courses for students up to the age of 20 or 21. These programs are mainly designed for sheltered employment but also lead to open employment. The establishments providing the programs include one (Hethersett, opened by the RNIB in 1956) whose object is to give short courses of further education to blind youth who need additional maturity, and also to give vocational assessment and guidance to help them choose between open and sheltered employment and the various types of training available for each (218). Every effort is made to see that students not only become aware of the range of occupations open to them, but also to enable students to have some practical experience on which to base a vocational choice. Periods of practice employment in factories and workshops introduce the students to work under normal conditions. The placement officers of the Royal National Institute for the Blind look over their progress reports, and visit the school twice each term to advise students and keep them in touch with employment prospects in the district in which they hope to work. The services of the youth employment officer are also available, especially for students living in areas not covered by the institute's placement service. Such help and observation facilitates their deciding on the right kind of training or job.

The Hethersett Center in Surrey for blind adolescents assesses their interests and abilities and provides some vocational training for assessment purposes. It is recognized by the Department of Education and Science as an establishment for further education under Part VII of the School Health Service and Handicapped Pupils Regulations, 1953. The center tries to provide conditions which are nearer to those of adult life in the community than are possible in the residential special school. Students are encouraged to join youth activities of all kinds in the neighborhood, in order to have the experience of mixing with sighted young people of their own age, experience which will be useful in making social contacts when they have finished training and start to work (331).

At the two grammar schools blind youngsters receive a more liberal academic education preparing them for professional careers, the main subjects being English, history, mathematics, languages, and geography. Some teachers complain about the time it takes to get books translated into Braille, but for subjects like history and English the Braille library is now being supplemented with tape recordings; for example, Worcester has a large collection of recorded books and plays. The teaching of science presents the greatest difficulties. Girls are taught domestic science, needlework, and weaving, whereas boys have classes in wood and metalwork, and learn to use basic tools, drills, lathes, and even a circular saw under supervision. One difference found when comparing their spare-time

activities with those of sighted students is that "blind children often turn their interests, whether cricket scores or the Beatles, into obsessions" (369). Concerts, drama, student societies, and dances are organized as at regular schools, and considerable time is devoted to sports, though conventional rules are often modified or disregarded.

Students remain at grammar schools till the age of 19 or 20, whereas the secondary modern schools provide mainly for children 11 to 16 years of age; even here, however, those enrolling late because their sight has failed later in school life may remain beyond the age of 16. Some who leave the grammar schools enter the universities. More boys than girls continue into higher education, preparing to become lawyers, masseurs, physiotherapists, or local government officers (295). The 140 places available at Chorleywood and Worcester are considered insufficient in relation to the estimated 1,400 school-age blind. At Chorleywood it has been possible to admit almost all the girls who apply but only by boarding some of them with nearby families. The Worcester College for blind boys turns away more than does Chorleywood. Those failing to gain admission to these two establishments have the alternative of attending the Royal Normal College, though some observers believe that the limitations of this choice create some hardship cases (369).

It is considered surprising that so little research has been conducted concerning secondary education for the blind. This may be due to the fact that the group is small compared with other categories of handicap, and the number born blind is declining. In Liverpool an experiment is taking place in which blind children are being educated in regular secondary schools, as a better form of preparation for work in the university than the traditional separation in a school for the blind (369). But no European country has yet experimented with education of the blind in regular schools to the extent that such provisions are found in the United States.

Partially Sighted

Partially sighted pupils are "pupils who by reason of defective vision cannot follow the normal regime of ordinary schools without detriment to their sight or to their educational development, but can be educated by special methods involving the use of sight."

In January 1964 the number of partially sighted children requiring or receiving education in special schools was about 2,100, with an incidence of about 1 in 3,400 (131). One medical authority has pointed out that in the 0-15 age group, congenital defects account for 60% of all cases, and myopia for 15%, whereas in the 15-49 age group the corresponding percentages are 25% and 20% (289).

Of the total of 38 special schools provided for the partially sighted, 29 are day schools, in contrast to provisions for the blind. Until the passage of the Education Act, 1944, most partially sighted chil-

dren were found in schools for the blind, since previous legislation had made no separate provision for them. They are now educated separately from the blind because by definition they can learn by visual means, even though with special equipment, and do not need to learn Braille. A further distinction is made, however, in ascertaining whether their needs are best met in the special school or in the regular school: (1) severe visual disabilities; to be educated in special schools by methods involving vision; 3/60 or 6/24 with glasses; or (2) visual impairment; to be educated at ordinary schools by special consideration; better than 6/24 with glasses. Thus the upper limit of visual acuity for those needing special schools is 25% of normal vision (131).

In addition to special schools there are special units or classes for the partially sighted in either regular or special schools. As for the blind, maximum class size is 15, though some of them are oversize. The extent of special adaptations in instruction and equipment varies considerably from one situation to another. In some regular schools there are no special conditions except that the teacher may put less material on the blackboard to be read or copied, and more discussions, incorporated radio programs, and large-print books may characterize the program. In some classrooms specially constructed for the partially sighted, however, there may be many special features such as an illuminated ceiling for shadowless distribution of light, extra large windows facing south, large-face typewriters, projectors and TV equipment, and a variety of portable or fixed lenses. The usefulness of such equipment varies from child to child; the teacher's treatment of each youngster is based on recommendations from the ophthalmologist and the school medical officer (131).

Most children in schools for the partially sighted have spent some time in a normal school where their defective vision was first discovered. Only the severely handicapped enter the special school at the beginning of their education. The use of large print and of magnifying lens makes possible a normal curriculum in the special schools. Writing, which starts out in large characters, has usually been reduced to normal size by the time the student leaves school. Arts and crafts are stressed; specialists visit the schools for this instruction. Crafts include weaving, pottery making, stencilling, linocutting, raffia work, cane work, knitting, and sewing. All girls of secondary age are taught housecraft in approved centers, and boys learn woodwork, metalwork, or both. Normal physical education activities are included, for only fast-moving ball games present any difficulty. Film strips are found useful as a teaching aid, especially in geography. Sports days, swimming events, and visits to concerts are arranged; dramatic performances are presented to audiences of pupils with normal vision, and school excursions are arranged in company with children from ordinary schools (295).

A Shropshire study recommended, however, that a fuller investigation be made of the means for enabling the partially sighted to attend ordinary schools, possibly through the use of the regular school for trial periods for these children, particularly in the case of those whose emotional problems may outweigh the claims for special educational treatment. The parents themselves need to be made fully aware of the alternative types of special educational treatment available, and the implications of each, so that they can understand the basis for whatever decision is made. Other recommendations concerning these children in the Shropshire study were that: (1) their progress should be reassessed at intervals, whether they are in an ordinary school or a special school; (2) a worker should be appointed to assess their progress and to advise about the desirability of transfer from a school for the blind to one for the partially sighted, or from a school for the partially sighted to the ordinary school (96).

There are no secondary schools specifically for the partially sighted. Pupils usually attend regular secondary schools. Increasing numbers of them are entering regular grammar schools at age 11, and technical colleges at ages 13 and 16, depending on their earlier program. The survey of provisions for the partially sighted in the Shropshire area concluded that since there were no grammar-school provisions for these youth there should either be specific arrangements to enable partially sighted youngsters of superior intelligence to attend regular grammar schools, or else a special grammar school should be established for them (96).

A possible extension of further-education opportunities for the partially sighted school leaver may result from a study which the Ministry of Labour has been asked to undertake over a four-year period concerning the careers of youngsters leaving residential special schools for the partially sighted. The purpose of this study is to ascertain whether these school leavers would have benefited from a period spent at a center for further education and assessment (27).

Deaf and Partially Hearing

Deaf pupils are "pupils with impaired hearing who require education by methods suitable for pupils with little or no naturally acquired speech or language." Partially hearing pupils are "pupils with impaired hearing whose development of speech and language, even if retarded, is following a normal pattern, and who require for their education special arrangements or facilities though not necessarily all the educational methods used for deaf pupils" (181). These two definitions represent changes made in the 1959 Regulations.

The category of "deaf" includes (1) those born deaf or who lost their hearing before learning to speak, and who have to attend a special school for the deaf; and (2) the hard of hearing, including

the wholly deafened, whose deafness occurred after speech had been acquired, along with some education as hearing persons. The latter are handicapped only to the extent of the degree of their inability to hear, and many with hearing aids can hear almost normally; the wholly deafened are often good lip readers and therefore can carry on a normal conversation. There are of course various combinations of types and degrees of deafness within these two categories (218).

Now as a result of advances in ascertainment and education of deaf children, a new and distinct group is emerging, those with speech, that is, those who had from birth little or no useful hearing even with a hearing aid, but whose normal means of communication is by oral speech and lip-reading. For some time to come this group will consist largely of young people who have had the advantages of modern techniques and training. It is recognized that this group will require special facilities for continuous auditory training and speech practice, and that some subdivision of the present broad definitions of the deaf and the hard of hearing will before long be required in order to identify this group and specify the type of help they need (218).

Today many children who would once have been classified as "deaf" are effectively treated as partially hearing, whereas many partially hearing children who would have received education in a special school are now placed in the regular school. This has been due in part to great advances in electronics and the production of small hearing aids providing much greater amplification and therefore more effective use of residual hearing. Also early ascertainment of hearing defects along with parental guidance and preschool education have led to better use of a child's residual hearing (153).

The proportion of deaf and partially hearing children varies considerably from one area to another, as shown by one study which indicates that Birmingham has 8.7 deaf children and 2.3 partially hearing children per 100,000 school population, whereas Coventry has 3.8 deaf and 13.0 partially hearing. Some of these variations may be due in part, however, to differences in provisions for special classes for the partially hearing (183).

As of January 1965, there were 3,280 children of school age receiving special educational treatment as deaf pupils and 89 awaiting admission to suitable schools, with an incidence of about one in 2,000. The corresponding figures for the partially hearing were 3,139 and 165 (341), with an incidence of one in 3,400 (131). These data exclude children with minor hearing defects educated in regular school classes, who are estimated to number between 3,000 and 4,000. The approximate number of places available in special schools and classes and voluntary schools for pupils with defective hearing are as follows (341):

Special schools for the deaf	2,700
Special schools and classes for the partially hearing.	2,000
Special schools for both deaf and partially hearing.	2,000
Independent schools	300

Total	7,000
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In spite of an increasing emphasis on the desirability of educating the deaf and partially hearing separately, in actual practice the distinction has not yet become as clearcut as in the case of the blind and partially sighted. The official 1963 list of special schools (186) indicates simply a total of 58 schools (28 day and 30 residential) for the deaf and partially sighted together, for while there are some separate schools for these two groups a number accept both types of youngster (131). Efforts are made to begin the education and training of deaf children as early as possible; in recent years more provisions have been made for children under five, both in special schools and through early home training for which parents are advised in some hospitals and centers (218). Class size is officially limited to 10, though many of them are oversize (368). For brighter youth there are two secondary schools, both residential and located in the southern part of England: the Mary Hare Grammar School at Newbury for boys and girls (the boys' section was added in October 1963 [176]), and the Burwood Park School at Walton-on-Thames with a technical and art emphasis. Also included in the total are two schools for deaf children with other handicaps (218). A school for maladjusted deaf children was opened at Stoke Pages in 1966 (334).

Although increasing stress is given currently to the inclusion of deaf as well as partially hearing youngsters in the regular school wherever possible, careful studies of the effect of transfer of deaf pupils from the special to the ordinary school have indicated the need for caution in arriving at such a decision. A Ministry of Education survey of deaf children who had been transferred in this way, concluded that only in exceptional circumstances may there be a possibility of academic success when the hearing loss is as low as 70 decibels over the speech frequencies. But even academic success does not guarantee adequate social and emotional adjustment; problems are likely to occur when transfer has occurred following the 11+ (post-primary selective) examinations.

There was the fourteen-year-old boy who could not summon up enough courage to join the social activities at his school even though he was a good footballer and was readily accepted as a team member. There was the fifteen-year-old girl who could not face the social demands of life and, in ill-adjustment, had withdrawn completely within herself. Observation of all the children showed the great strain

that they must endure in order to maintain their identities amongst people who are so much better endowed than themselves and who hear well (190).

A recommendation for transfer of a severely deaf child from a special school to an ordinary school should be made not by one person but as a result of consultation with parents and observation and assessment by a team of workers including medical officers, head teachers of special schools, and head teachers of ordinary schools who understand the educational and social problems imposed by an auditory handicap.

Experts have pointed out that there is no one answer, such as special classes attached to normal schools, to the educational problems of the hearing impaired child. Careful attention must be paid to the individual child and numerous factors in his case such as: type, degree, and age of onset of deafness; age of ascertainment and response to preschool training; powers of auditory discrimination and ability to profit from hearing aids; ability to develop communication skills; presence of additional handicaps and emotional and neurological involvements; intelligence, temperament, and personality; attitude of the family toward the child and his handicap.

What is required is not the establishment of one form of provision only but maintenance of a flexibility of approach and a system of easy transfer according to current needs.

Constant improvement of all types of educational provision, more research into many aspects of this work, better training for all concerned with the management of deafness in childhood—all these are needed (350).

Most special schools for the deaf tolerate the sign language but carry on their teaching by the oral method. One writer argues that only a small proportion of children really grasp lip-reading and speaking well enough to make these a normal mode of communication, while for the rest much school time is wasted in learning such skills, time that could better be spent in imparting knowledge about the world through the sign language. Thus when reaching school-leaving age they are less well informed than they should be, less well prepared to adjust to life outside the special school (402).

A reconsideration of the role of sign language in the education of the deaf is now being undertaken by a special committee, under the chairmanship of Professor M. M. Lewis, appointed by the Secretary of State in September 1964 (53). The committee's assignment is "to consider the place, if any, of finger-spelling and signing in the education of the deaf." The committee met three times in 1964, and expected to take two years in all to complete its study and issue a report (177).

A number of adolescents have gone deaf because of meningitis, in which case immediate rehabilitation is extremely important. Though later difficulties with articulation are not so great as in cases where the deafness has occurred during childhood, there is danger of loss of self-confidence which may hamper the adolescent's personal and social life. Some training in the use of a hearing aid, together with lip-reading instruction, is a minimum requirement in every case; it may sometimes take the youngster several months to get used to the hearing aid (363).

Although efforts are made to enable deaf children to mingle with the hearing, it is inevitable that many deaf school leavers who have attended residential schools, some located in rather isolated places, have little idea about what the world outside is really like. The school's concentration on the needs of the deaf pupil, admirable though this is, may at the same time give the youngster a false impression of the amount of attention and consideration he will be given after he leaves school; he may find it hard to become independent and self-sufficient. To meet this need, schools for the deaf arrange visits to factories, government offices, and civic and social events, and participation in games, sports, and scouting activities, some taking part in national and international competitions arranged by the British Deaf Amateur Sports Association. Like other adolescents, deaf youngsters like dancing, and some of them become very good dancers (49).

One of the most serious difficulties they face is the obtaining of further education. They can usually manage the practical part of technical or professional training courses, but the lecture work is beyond them unless they get special help. If there are half a dozen of them who wish to take the same course at a technical college, the local education authority will provide them with a specialist teacher of the deaf, who will sit beside them and interpret or help them in other ways, but this arrangement is possible only in large cities because it is not considered practical to provide it for only one or two trainees. Further education is considered to be one of the aspects of the provisions for the deaf which most urgently needs investigation on a national basis (49).

There is considerable evidence that in spite of their urgent need for further education, the facilities for youth with normal hearing are not suitable for deaf school leavers because of the problems of communication, both in understanding material and in expressing ideas. The National College for Teachers of the Deaf has stressed that the essential requirement of a teacher or an interpreter for the deaf is that he not only know how to translate acoustic into visual symbols but also have an understanding of the way in which the deaf youngster learns. A special committee on the handicapped school leaver has recommended "that local education authorities be

urged to give consideration to the establishment, on a regional basis, of residential courses of general education as a preliminary to vocational training of the physically handicapped" (97).

It was pointed out in a conference sponsored by the National Institute for the Deaf that in order for further education to be made more generally available to the deaf, "education authorities must realize that for some types of classes it will be necessary to appoint sympathetic teachers, who will work with interpreters, in order that the best results be obtained." When deaf students take external examinations, they need impartial interpreters, because examiners frequently ask questions in language that is not understood by the deaf, who consequently do not know what is required of them. Interpreters must translate such questions into the more limited vocabulary understood by the deaf, without of course in any way helping with the questions. Since many deaf adolescents have been unable to complete existing courses in further education, local authorities should establish special evening and/or part-time day classes for the deaf at one of their local institutes or in a local school for the deaf or welfare center for the deaf, with the cooperation of the managing bodies and heads of staff. The problem of an adequate vocabulary is compounded by changes within trades themselves. For example, in the trade of bakers and confectioners in which many deaf persons have succeeded so far, a change has occurred in that the apprentice must go to the appropriate technical college to learn not how to bake or be a confectioner, but he must learn about such things as food preservatives, which introduces a whole new vocabulary that is beyond him without the help of a skilled teacher of the deaf or an interpreter. It was suggested that the Association of Education Committees, the Association of Technical Institutes, and the National Institute for the Deaf set up a joint committee to investigate this situation and make a report (264).

Recognition of the fact that some deaf children are only functionally deaf—have no defect in their hearing mechanism—has led to research and special provisions for them. The Manchester Education Authority, at the invitation of the Department of Education and Science, established a small residential diagnostic unit and school for the investigation, treatment, and education of this type of child and of others not progressing in schools for the deaf. This new school works closely with Booth Hall Children's Hospital and with the Department of Audiology and Deaf Education of Manchester University. A broadly similar school was opened in the south of England by the Invalid Children's Aid Association, again by invitation of the Ministry (183). A third new school, the Larchmoor School for maladjusted deaf children, with accommodations for 11 girls and 14 boys aged 7 to 16, received its first pupils in February 1966; it was established by the Royal National Institute

for the Deaf because of the realization that many deaf and partially hearing children suffer from emotional problems (85). Their special needs have been stressed in conferences organized by the National Deaf Children's Society (176).

Whereas deaf children are almost all taught in special schools, there are many classes or units for the partially hearing in regular or special schools. Their classrooms usually have acoustically treated walls and special hearing apparatus. On the secondary level, however, the partially hearing youngster more frequently attends regular classes in ordinary schools, where sympathy and cooperation are needed to enable him to adjust to the extraneous noise and echo effects he encounters (131). In September 1947 London opened its first class for partially hearing children, attached to an ordinary school. The need was such that special classes were soon provided in three other schools, the number of classes in each school varying from two to four. Other communities followed this example, so that by January 1962 there was a total of 79 such classes. The purpose of the classes is to help the child to become integrated more and more completely into the program and activities of the ordinary school.

The problem of providing such classes proves more difficult at the secondary-age level; although there are classes for the partially deaf in secondary modern schools in London, Middlesex, Manchester, and Newcastle, few local authorities in general have set up special classes for senior age children. For many years London dealt with the situation by retaining children in the special classes attached to primary schools until the age of 13 years, when a decision had to be reached as to whether the child was able to cope successfully with an ordinary secondary school or whether he needed to be admitted to a special school for the deaf or partially hearing. Recently, however, London opened two special classes for senior children. Other authorities feel no need to provide such classes, for the few children leaving junior special classes at the age of 11 who have failed to pass on to ordinary schools before that time are placed experimentally in various secondary schools where it is felt that their needs can be met. In this case continuous supervision by a teacher of the deaf is provided, either by his visiting the secondary school or by the child's returning periodically to the special class for short sessions of auditory training. In some areas peripatetic (visiting) teachers of the deaf supervise these children in ordinary schools (183).

A unique form of supplementary assistance for partially hearing youngsters of secondary-school age has been initiated recently by the Surrey Education Committee. Designed for young persons with marginal hearing loss who do not need full-time help, a specially equipped air-conditioned sound-proofed van travels through Surrey,

stopping at secondary schools. Though schoolwork is still done in the regular classroom, two speech trainers, working with two pupils at a time, help them with their special difficulties and enable them to hear and speak better so that they can get along more easily in the life of the school (38).

Physically Handicapped

Physically handicapped pupils are "pupils not suffering solely from a defect of sight or hearing who by reason of disease or crippling defect cannot, without detriment to their health or educational development, be satisfactorily educated under the normal regime of ordinary schools."

In January 1964 the number of physically handicapped children receiving special educational treatment or awaiting places in special schools was 11,067, with an incidence of about 1 in 640. A large northern city with a 1963 school population of 110,052 was providing 220 places in its schools for the physically handicapped, in addition to providing instruction in the hospital or in the home (131).

In 1963 there were 49 residential schools for the physically handicapped, of which 8 were secondary schools. There were also 132 day special schools for the physically handicapped and delicate combined, of which 3 were secondary—the largest single group of special schools (186). Many local education authorities make no provisions themselves for the physically handicapped, but instead send such children to schools operated by other local authorities or by voluntary organizations, such as those of the Shaftesbury Society and the National Children's Homes. Some authorities send a few physically handicapped children to their open-air schools, and about 1,400 are taught in their own homes (131).

An example of a special school for physically handicapped youngsters is the Coventry School described by Miss Mary McBride, of the Ministry of Education, at the International Seminar on Special Education held at Nyborg, Denmark, in June 1963. Run by the city of Coventry, it is the focus each morning for a stream of buses, taxis, and ambulances bringing children 3 to 16 years of age to the school. Specially devised equipment is also being used now, such as a hydraulic tail lift for putting wheelchairs into the back of a small bus. Polio cases and multiply handicapped cases are increasing. There is a varied program to provide all the things young children want to do, such as exploration, discovery, and just "getting into a mess." The staff includes over 20 teachers, 4 physiotherapists, a speech therapist, 2 remedial gymnasts, 6 housemothers, a visiting teacher for the deaf, and a health visitor. Even the handyman, an elderly carpenter, is a great asset. The children do not have to leave the school for medical consultation since the specialists come to the

school, usually every other week. The mother is also an important figure, for she always sits in on conferences with the consultants, sometimes with the father as well.

Some physically handicapped children make sufficient improvement to transfer to a regular school, but since special schools for this group are usually all-age schools, and since the children's handicaps are more or less permanent, the majority stay at the same special school for their entire education. Some communities have been more successful than others in educating physically handicapped youngsters in regular schools. For example, a 1963 inquiry in the Midlands and North Midlands revealed that 156 severely handicapped children, some of them limbless, were being successfully educated in regular schools. As experiments of this kind continue, it is expected that larger numbers will transfer from the special schools (131).

The Department of Education and Science is continuing a survey of the adequacy of provisions for the special educational treatment of physically handicapped and delicate children, especially the following groups:

1. The increasing number of children who are surviving spina bifida. Places in special schools made available by the decrease in the number of children with polio will accommodate nearly all of them, but one new boarding school is to be built by the Sheffield local education authority.
2. The children with limb deformities resulting from the use of thalidomide drugs during pregnancy. It is believed that most of them can be taken care of in existing regular and special schools.
3. Children with hemophilia (53, 177).

Special problems are presented in attempts to provide education, particularly on the secondary level, for physically handicapped youngsters.

The extent to which each child can make adequate use of his innate intelligence depends very largely upon the nature and severity of his physical handicap. From an educational point of view, the most lightly handicapped children are those with lower limb paralysis resulting from poliomyelitis. Able to use arms, hands and their five senses to the full, the fact that they may be chair-bound detracts very little from their ability to profit from formal, academic education conducted under normal classroom conditions. Conversely, one occasionally encounters a very severely handicapped athetoid child of high intelligence. His inability to speak intelligibly, to write or even to feed himself and to attend to personal toilet so frustrates him that he often has quite serious emotional disturbance. An electrical typewriter which he

can learn to operate with an alloy rod on a head band, can prove invaluable as the only means of communicating with others, but even with this the child is only able to apply a fraction of his innate ability (19).

Special equipment and materials are used wherever possible, as in teaching science at the Chailey Heritage Craft School, where easily portable kits contain all the necessary equipment for about 30 experiments in one branch of elementary science, supplemented by television science lessons (19).

Bright physically handicapped youngsters can obtain secondary education at one of two grammar schools at Alton, one for boys and one for girls. The program of the Lord Mayor Treloar College for physically handicapped (chiefly orthopedically handicapped) boys, as reorganized and expanded in 1953, provides general education for 70 boys 11 to 16 years of age, and technical education for 60 boys over age 16, along with an hour and a half of general education daily. In 1956 two full-time programs for boys 11 to 16 years of age were introduced — a grammar-school course for the more able boys, and a course similar to that of a secondary modern school for the less able boys. A commercial course was added to the offerings for the older boys to vary the more traditional trade training (168). The Lord Mayor Treloar College now also includes a residential grammar school for girls (131).

A group to whom attention has been increasingly directed in recent years are the cerebral palsied. These are called "spastics" in England, though some educators have pointed out that the term is used incorrectly to refer to the entire group of the cerebral palsied since it actually designates only one type of involvement (131).

It is estimated that there are over 70,000 spastics in Great Britain, and that over a thousand boys and girls reach working age each year (355). While there are no exact figures for the prevalence of cerebral palsy in adults, 0.5 per 1,000 is an approximate figure, with 1 or 2 per 1,000 of school age (97).

Because of the comparatively large numbers of cerebral palsied children and their common problems, some schools have been established for this group alone — a total of 18 was operating in 1963 (184). Since the IQ range covers the entire range of intelligence — from below 50 to over 140 — attempts are made in the educational grouping of these children to keep youngsters of similar intelligence levels together. It is found that there is disruption of general rapport or group spirit if one person is much above or below the intelligence level of the others, as in the case of the bright boy who takes advantage of his less bright companions by constantly borrowing money from them. Grouping might be done in terms of the school as a whole, or by creating sub-groups among the pupils in a given school. An example of the first kind is that of Ponds, a home for 33 boys

and girls, mostly between 16 and 21 years of age, with cerebral palsy and normal intelligence, and with no secondary handicap such as epilepsy or incontinence. This was established by the British Council for the Welfare of Spastics at Seer Green, Buckinghamshire. Diversionary activities are provided, and where necessary Ponds will provide a permanent home for those unable to support themselves or look after themselves, who might otherwise find themselves in the chronic wards of hospitals or in large residential homes (286).

Either grammar-school or secondary modern education can be obtained by cerebral palsied youth at the Thomas Delarue School established at Towbridge, Kent, in 1955. The first university entrant from the grammar-school program was a boy admitted to Edinburgh in 1961 to study agriculture, while the next year a girl entered London University to study theology. Some students in the secondary-modern program follow a commercial course and take the examinations of the Royal Society of Arts in shorthand, typing, bookkeeping, and accounting. This program provides for the less academically minded and has a practical basis, but all students have classes in housecraft, wood and metalwork, art and various crafts, and all share in the activities of the school societies, clubs, games, and sports (355). An interesting experiment in the summer of 1964 was the exchange of 30 of the grammar-school students with a similar number from the Geelsgaard School in Copenhagen.

The first experiment in higher education for severely handicapped spastic youth aged between 18 and 25 years was begun in June 1964 in the Essex village of Kelvedon. A spacious new building called "Oakwood" provides full residential care for up to 20 youngsters, and comprises single and double study-bedrooms, and a students' dining room, lounge, and library. There is a full-time houseparent, plus a domestic and secretarial staff. English, French, history, art and mathematics are taught chiefly by visiting tutors who come to the school for about four hours each week. Efforts are made to create a student community and an "outward-looking" attitude on the part of the student. Group therapy and the planning of parties and social evenings have been found helpful. But as one tutor expressed a basic problem in educating these youngsters, the purpose of Oakwood may have to be to make the youngsters accept the fact that for the rest of their lives most of them will have to accept dependence on parents and on the Spastics Society, and accept it graciously. While it is natural for them to think in terms of preparing for well paid and independent work (IQ's at present range from average to 148), they must be encouraged to face the future realistically and to recognize that the development of broader interests and the gaining of intellectual satisfactions are important ends in themselves (79).

Further education is increasingly available to youngsters with cerebral palsy. The Delarue School moved in 1963 to new quarters

half a mile from its former buildings, which are now used as a further education center for 45 persons, with a year's program. Further education is also available for 22 young spastics (13 boys and 9 girls) in a winter program at a holiday hotel at Colwall Court, Behill-on-Sea, with a full educational and social life (144). Some further education classes are conducted each week at Coombe Farm in Croydon, Surrey, a residential center for 45 severely handicapped spastics aged 16 to 25 (355).

The Spastics Society has organized a further education course for the cerebral palsied, of six months' duration, with 18 students in the first such course given, and twenty in the second. Most of these young people found the program helpful and enjoyable, and in nearly every instance parents wrote later expressing their appreciation for the marked improvements they had noted in their youngsters. These young people were all known to the Society's Employment Department, and were potentially employable in either open or sheltered employment, in a work center, or at home. Though the degree of physical handicap was in most cases mild, they were all immature and below average in intelligence, many also having additional handicaps such as epilepsy and partial sight. The lightly handicapped intelligent young person is no problem unless he is emotionally disturbed, and the intelligent very severely handicapped youth is usually not employable; so these types are not included in the course. The young person is considered to have employment possibilities if he has reasonably good use of one or both hands, can comprehend simple instructions, can concentrate for long enough to complete a routine operation, and has a reasonably mature approach to other people and to this work. The further education course includes basic education, practical work, personal training, social activities, and group activities (269).

Two brief case summaries from the group of 10 boys and 10 girls taking the second further education course given by the Spastics Society at Colwall Court, illustrate the kind of difficulties the youngsters bring to the course, and the progress that may result; only the names have been changed:

Pamela, aged 16 years. Right hemiplegia: petit-mal.

Attended Secondary Modern School (in slow stream). Very self-conscious and tended to use handicap as an excuse for being helped: over-protected and very emotional when younger. Has shown improvement on educational and social sides of the Course, and personality has brightened considerably. It is felt that she might manage a job in a shop, alternatively that she should put forward an application for Sherrards. Has been in touch with the Y.E.O. (youth employment officer) and has obtained employment on a trial basis.

Michael, aged 16 years. Left hemiplegia.

Attended Open Air School until sixteen: below average attainments. Backward, lacking in initiative and concentration, not ready for training on leaving school. Little gain noticed during the first part of the course, but during the second term proved most willing and enthusiastic, especially in the practical subjects. Developed into a pleasing and quiet personality. It is felt that he required further training, and application to Sherrards has been recommended. Has been referred to the Y.E.O. in view of the Ministry of Labour's recommendation that he could be found employment without much difficulty, and follow-up for training will be made if found necessary.

Major goals in the special education of cerebral palsied youngsters, as for those with other kinds of physical handicap, are the development of manual dexterity, independence, socially acceptable behavior, and adequate leisure-time interests (45). The woodwork, metalwork, art, homecraft, cookery, and needlework are given not for vocational training as such but primarily to give manual dexterity. Curricular content is determined by the practical needs in everyday life, such as acquiring the ability to handle money effectively, read fluently, speak clearly even if imperfectly, use the postoffice and savings bank, travel by railway and bus, and know something about sports, the theatre, music, and art. To achieve independence the students at the Delarue School have an "independence week" in the first term of their final year, during which, while sleeping and dressing in their dormitories as usual, they do as many other things as possible for themselves such as shopping for food, preparing and serving meals, and making beds. In the final term school leavers experience another independence week, and results for the two weeks are compared.

Speech and occupational therapists cooperate in helping the youngsters to acquire socially acceptable behavior, such as learning to eat properly and tidily. Physiotherapists visit the dormitories to see that students are making progress in bathing, toileting, and caring for their clothing and persons. Appearance and manners are made more evident by hanging mirrors at different heights all over the school. Also of help are talks with the older girls by an expert on makeup, or fashion shows given by the girls themselves.

Among the leisure-time interests developed are chess, a rabbit club, record playing, television, special games such as modified cricket and chair hockey, and swimming. Teachers arrange for group visits to factories, offices, banks, and places of historical interest, and the students are encouraged to go out on their own to shop, to visit amusement places, and to join local cultural and religious organizations. Groups such as the Red Cross and Rotary Club and those connected with local churches work together in a

group known as "Friends of the Delarue School" to give voluntary aid in various ways.

An especially troublesome question is education for life after school of the severely handicapped youngster who is unlikely ever to be employable. The most baffling and distressing problem is that of the intelligent youngster with severe athetosis plus a considerable speech defect, though he can take the academic course and participate in school activities as a listener and observer. The severely disabled pupil with the ability to communicate orally or manually can be encouraged to continue his learning. At best such youngsters can be provided security in a familiar and sympathetic environment, and simple occupations and interests which are within their physical capacity (45).

As indicated earlier, children with spina bifida now survive more frequently, because of early surgery and improved medical care. The number with spina bifida in the general population is estimated at 2 or 3 per 1,000, though some observers believe the actual prevalence is higher because, among other factors, children with a minor defect might escape detection. Most deaths occur in the first year of life. In one survey, it was found that about 0.4 per 1,000 preschool children are admitted to hospitals for treatment, but less than 0.2 per 1,000 of school-age children. Another study indicated that at least 800 to 1,000 spina-bifida babies are being brought into the care care of the health service each year. Since early surgery can prevent the development of hydrocephalus, fewer youngsters with spina bifida now prove to be mentally retarded. The first school specifically for children with spina bifida was established as recently as 1959, but many can attend regular schools, where their chief problem is the practical coping with urinary incontinence (184).

There are about 300 children in England and Wales known to have defects resulting from thalidomide. Of these, about 150 have gross limb deformities, including 36 with no arms; 3 have no legs; and 12 have neither arms nor legs. Actually there have always been children with deformities of this kind, but public attention was attracted to this group in particular because of the large number born in a relatively short period. Although at present most severely physically handicapped children are attending special schools—7,134 in January 1963—others make satisfactory progress in regular schools if they receive sympathetic cooperation and emotional support. Where such help is available, thalidomide children can also attend regular schools (184).

Also included in the category of the physically handicapped is the hemophiliac. It is estimated that there are 2,000 boys and men with this affliction in Great Britain (280).

By means of cooperation between the parents of the hemophiliac boy and the school doctor and nurse, the teaching staff, and the gen-

eral practitioner responsible for treatment during attacks, a fairly normal life in and out of school may be possible for the boy. It is usually considered desirable to try to send him to an ordinary school, where he can have normal educational and social experiences, if the teacher knows what to do in cases of injury, how to get help, and how to enlist the cooperation of classmates (3). It is equally important for the teacher to be understanding, to be able to advise, encourage, and warn, to soften the "don'ts" and help with the "do's." Since education in school will be interrupted by periods of illness and inaction, continuity of some kind must be made possible in the boy's educational work (115). If the episodes are frequent and severe, home instruction may be preferable. Or the boy can attend a day school for physically handicapped or delicate pupils, with smaller classes and more individual attention than he would find in the regular school.

When the child arrives at secondary school age the question of attendance at a residential school will have to be considered. It is important at this stage that the child should not have repeated interruptions in his education—time is important to him, and much time may be saved by the simple means of living at school, so that education can be continued when he is obliged to stay in bed (3).

The activities of daily living will continue to present problems to the boy while in school and in life after school. To lessen risks he must try to avoid traveling in rush hours or boarding crowded vehicles. He can take part in only certain kinds of sports: swimming is good exercise, tennis is a fair risk, but football and cricket must be avoided. Most dangerous of all is casual play; he may need to substitute chess, clay modelling, the use of hand tools, and fishing as forms of recreation (115). Even minor surgical operations like tooth extractions require great care and sometimes a long hospital stay, which may interrupt education and employment and limit leisure activities. However, in spite of such difficulties, many are able to lead full and normal lives, particularly if they have the support and encouragement of family, friends, and associates (92).

The actual number of persons with muscular dystrophy is not known; because it is not infectious or dangerous to others there is no requirement that cases be reported. But it is estimated that there are about 10,000 potential or actual victims with the most common type, the Duchenne type, that is a sex-linked recessive factor, and that usually makes itself evident in the child's difficulty with motor coordinations around the age of three. Children with muscular dystrophy are encouraged to attend regular schools to the extent that their disability permits. The youngster usually lives at home, unless for various reasons he cannot be cared for adequately by his parents (278).

Local education authorities and other groups were consulted by the Department of Education and Science during 1965 about provisions for the further education of handicapped school leavers, and one outcome of this consultation was the Department's approval of the Coventry authority's plans for a Further Education College for the Physically Handicapped which would provide places for youngsters from all over the country (53).

Delicate

Delicate pupils are "pupils not falling under any other category in this regulation, who by reason of impaired physical condition need a change of environment or cannot, without risk to their health or educational development, be educated under the regime of ordinary schools." Anemia, general debility, chronic respiratory disease, and diabetes are included, but not cardiac complaints.

In 1963 there were 11,414 delicate children requiring or receiving special educational treatment (131). Many are educated in special schools with the physically handicapped, in addition to the 53 residential special schools, including five on the secondary level, for the delicate alone (186).

The role of the "open-air school" has changed considerably in the last thirty years. Copied from German schools of the early twentieth century, this school had the original purpose of providing for children with "impaired vitality due to anemia, malnutrition, incipient forms of lung and heart disease and unfavourable living conditions" (131). Fresh air, sunshine, good food, and ample rest were considered especially important, and formal school work was secondary. At present, however, a higher living standard and better medical and welfare services have sharply reduced the incidence of malnutrition and neglect, even though such factors as slum conditions and parental indifference have not disappeared. Children in special schools for the delicate more commonly now have asthma, bronchitis, and debility. The need for rest is stressed less, and formal school work often differs little from that of regular schools. These special schools also include other handicapped children found difficult to classify, referred to by some educators as "the kind of children no one else wants" (131). Some have mild physical handicaps or are slightly maladjusted; they need more sheltered conditions than the regular school can provide but do not require intensive treatment. Other children may have rheumatism, mild epilepsy, brittle bones, or "nervousness." Thus the term "open-air school" no longer accurately describes the schools for the delicate. Although some children may stay in these schools for less than a year, most of them stay longer, and those with more serious or chronic conditions may stay for their entire schooling. Maximum class size is officially 30, and

few classes exceed this maximum. Regular medical supervision is provided, as well as the drugs, treatments, and special diets that may be needed.

There are 4,000 diabetic children in England, out of a total of about half a million diabetics in the United Kingdom, according to an estimate of the British Diabetic Association (12). Diabetes is said to be one of the major causes of death in England at the present time.

There are no separate special schools for diabetic children; most of them are considered capable of attending regular schools, while others attend special schools for the delicate. The condition is controlled by a combination of insulin injections and special diet. It has been suggested that children over 7 years of age should learn how to measure and give their own injections of insulin. In cases where the youngster with diabetes needs special provisions, arrangements can be made for him to live in a hostel or boarding home especially for diabetics while attending a regular local school. It is only in cases where dosages of insulin or modifications in diet are required frequently that the youngsters need the close supervision received at these hostels (149). The British Diabetic Association, though not providing hostels directly itself, has secured five of them for diabetic children by cooperation with the Church of England's Children's Society and the National Children's Home and Orphanage (286). The London County Council maintains a hostel for diabetic children who need treatment away from home; they come from all over England. Here the youngsters are taught to understand their special needs and administer their own injections under the supervision of nurses. Arrangements are made for parents to visit the hostel and receive instruction in their child's daily care so that they can be reunited with the child at home as soon as possible (153).

As other handicapping conditions decline in frequency, some like respiratory disease are left in a position of relative prominence. Asthma and bronchitis together now form the single largest category of disease among the boys and girls in special schools for delicate children. It is estimated that 100,000 children in England are asthmatic (183). A Birmingham survey revealed an asthma prevalence of 1.84% in six-year-old children, though many more boys than girls were afflicted (2.58% versus 1%). The picture changes as the child matures, for in this study, by the age of 13 to 15, the figures were 1.96% for the boys and 1.2% for the girls. By early adult life the picture has changed still further, so that asthma occurs with equal frequency (0.9%) in the two sexes (352). Since the incidence of asthma decreases with age in the school group it is much less of a problem for school leavers than for school entrants.

About 10% of asthmatic children suffer sufficient loss of school

time to make it difficult for them to keep up with their education. But in the vast majority of cases no structural damage is done to the lungs, and full recovery is possible eventually, even where the condition has existed for many years and where the chest wall has been deformed by the occurrence of severe asthma in early childhood. The risk of death is small, but is significant in a few severe cases. The asthma does retard growth to some extent, and these youngsters usually do not grow as tall as non-asthmatic children. There is evidence of an allergic background in 70% of these asthmatic children. Special schools are available for the 10% with severe cases of asthma. It is recognized that they need a solid basic education, not just holiday homes (352).

Experience in Birmingham led to the conclusion that 90% of asthmatic children can attend ordinary schools; they are encouraged to do so if the school is not too far from the home and if the teachers are sympathetic. When asthmatic children reach secondary-school age they are usually able to cope successfully with the work and conditions in the regular school, though there are always a few who would benefit from attending residential schools. At the time of puberty the symptoms of asthmatic boys tend to diminish, though in girls the improvement is less marked, and their symptoms may actually be aggravated in some cases at the time of the menstrual period. Prognosis depends not only on severity of symptoms but also on early diagnosis and wise handling. For purposes of educational placement three main groups are distinguished:

- (1) those whose asthma is chronic but not severe, who are lacking in confidence, and need a short stay in a residential school;
- (2) those with chronic severe asthma, who need regular drug treatment, but who do not present any particular emotional or social problems;
- (3) those with intermittent but severe asthma, in whom attacks are associated chiefly with emotional disturbance. (183).

An example of a residential school for respiratory and allergic conditions is that of Brentwood's School, St. Leonard's, established by the Invalid Children's Aid Association, for 30 girls aged 9 to 16. In addition to asthmatics there are girls with other bronchial and allergic conditions. The girls are found to have more emotional upsets and problems than a similar group of boys. A disfiguring disability such as eczema is harder for them to accept; teasing by other children may cause them to insist on wearing trousers and long-sleeved blouses to hide the skin condition.

One girl, after a lifetime of Hospitals and Doctors, could not make satisfactory relationships with other children.

After a year at Brentwood she was seen at home in a short skirt, quite unself-consciously giving a scratch to an irritating patch, and talking quite freely about her skin condition. She and her family have now accepted her bad skin as one of the things they have to live with (129).

Girls thinking chiefly in terms of marriage are less enthusiastic about academic work than boys, but still need to be encouraged to acquire a basic general knowledge and to use their academic ability to the full. Some of the older girls take shorthand and typing. Sedentary secretarial work is especially important for the more delicate asthmatics or bronchiectetics. Domestic science is aimed more at homemaking plans. The care of clothing and attention to personal appearance are stressed. Rollerskating, netball, and tennis are available.

Epileptics

Epileptic pupils are "pupils who by reason of epilepsy cannot be educated under the normal regime of ordinary schools without detriment to themselves or other pupils."

One estimate is that there are over 10,000 epileptics in the mental hospitals of England and Wales, and at least 100,000 outside institutions (76), with an incidence of 4 per 1,000 of the general population (183, 203). For a total population of about 55,000,000, this would give a figure of 220,000. There are many factors which make it difficult to arrive at an accurate estimate. The number of cases ascertained in school medical inspections rose from 3,021 in 1938 to 19,015 in 1961, from an incidence of 0.6 to 2.7 per thousand school children, though this reflected more complete ascertainment rather than an actual overall increase (183).

It is difficult to get agreement as to incidence of epilepsy among school children 5 to 15 years old; surveys made in England over the past 15 years have provided incidence figures per 1,000 children ranging from 0.62 to 4.62. One reason for the range is difference in the definitions adopted for epilepsy, and in the criteria for determining when a child can be said to have epilepsy. The estimate from a survey of the College of General Practitioners is considered most reliable since the general practitioner is likely to be the first person to whom parents would refer a child with seizures. A child was not counted as epileptic unless he had had continuous treatment for two years before the start of the survey; this gave an incidence figure of 4 per thousand. Of those whose first seizure had occurred during the survey year, 45% were over 15. The fact that school doctors are becoming increasingly aware of epilepsy among school children reflects in part a change in social attitudes that makes parents less reticent about discussing such cases (183).

Effective integration of epileptic youngsters in regular schools depends to some extent on the development of greater understanding and acceptance on the part of the public in general, the teachers, and school classmates.

School-children dislike sitting next to a boy who at any time may give a loud cry, fall on the floor with a thud, and go off into convulsions from which he will emerge with a strong smell of urine on his trousers (76).

But even grand mal episodes can be understood and accepted in school and employment situations with the proper kind of cooperation and explanation. Teachers have learned that sensible precautions can protect the child even when major seizures occur. Obviously close cooperation between home and school is important in order to assure satisfactory placement in an ordinary school. Aside from rejection, pampering or unnecessary restriction of the child's activities could have undesirable effects. Swimming, for example, is permissible when the group is small and the pool is not crowded. The school doctor usually tells the teacher what to expect, and what to do for the child; he also makes annual checks on the child. Placement in a special school is considered only when the child shows markedly undesirable behavior, is educationally subnormal, or has very frequent attacks (183).

Before the onset of seizures there is nothing about the child that makes him either more or less likely than the normal child to be mentally subnormal, though an injury causing epileptic seizures might also damage mental functioning. Whatever the intelligence level of the epileptic child, the risk of mental deterioration has been exaggerated. Repeated major convulsions might have this effect, but these are rarely seen in children today because of drug therapy. Personality changes resulting in psychological difficulties occur only with the partial, temporal-lobe type of epilepsy, and even here just one child in three with this condition shows personality disorders. Sometimes a particular drug may produce behavioral changes, as when phenytoin causes impulsive and hostile behavior. Of course psychological disturbance may occur which does not manifest itself in anti-social behavior. Caution is exercised about ascribing personality disorders directly to epilepsy without first investigating the environmental background of the child. The *prevention* of personality disorders in epileptic children is more important than their *treatment* since more of these disorders are due to misguided care than to cerebral disfunction, and the school doctor plays a key role in the prevention.

Drugs are increasingly effective, with all but a few children, in removing or reducing the frequency of seizures. Anti-convulsant drugs may need to be taken for long periods of time even after the

seizures disappear, except for petit mal seizures for which remission may occur at the time of puberty and adolescence. The effects of drugs depend on prescribing the right kind and the right amount, and taking them regularly. Some adult cases of epilepsy of the focal type have been improved by neurosurgery. It is believed that in no other condition is it more important to treat the whole child and not merely his symptoms. Treating the child within his environment has the aids of (1) removing where possible the physical and psychological factors precipitating seizures; (2) controlling the seizures through the use of appropriate drugs; and (3) helping the child and society to adjust to each other. Certain drugs have been found specifically helpful, although their mode of action is not clear (183).

The number of children with epilepsy who need to attend special schools seems to have stabilized at about 750. Some of the schools for this group are in premises which were built during a period when a different view was taken as to the purpose of a school for epileptics, but programs of modernization and building replacement are being undertaken (175).

One survey indicated that 60% of the children in special schools for epileptics were in the senior age group (12 to 15 years of age). Of the total in these special schools, 40% had IQ's under 70, and on admission 4% had IQ's under 50. This is an indication of the increasing severity of the handicaps of children admitted to these schools, and the willingness to let them have a trial of education in regular schools. In this same survey, 60% of the children had their first seizure after the age of 5. Age of onset in part determined the age of admission to the special school, and less than 7% were admitted after age 13 (5.5% at age 14, 1.4% at age 15). Over half attended less than two years (53.5%), whereas 20% had attended for more than 4 years. Severity of epilepsy was found as follows: 29% severe; 18% mild; 31% intermediate; 22% free of seizures for the preceding 12 months (183).

Doctors and teachers working in these special schools have noted an apparent increase in recent years of children aged 13 and over admitted because of increasingly awkward or unmanageable behavior. They claim that earlier detection and help might have prevented the development of such behavior, though there must be further research to indicate what percentage were temporal-lobe cases with intractable personality changes. In the period 1955-1960, of the total of 1,204 children leaving special schools, 32.3% left because their seizures were controlled, 32.3% left because they reached school-leaving age, and 35.4% for other reasons, which included 8.9% who left because of their behavior. It is not surprising that a larger percentage of those admitted between 5 and 10 years of age left because of controlled seizures, and a smaller percentage because of reaching school-leaving age, than of those admitted between ages

11 and 15. Of the children in these special schools in 1960, 15.5% were 13 years of age and over. Nearly 60% of those staying till age 16 had spent more than three years in the school. Nearly half of those discharged because they were 16 had been admitted after their 13th birthday and were still having seizures. More boys than girls are discharged because seizures are controlled, but also more boys than girls are discharged because of behavior. Epileptic children are being admitted to special schools at an earlier age than before; most of them are now multiply handicapped and their additional handicaps are more severe than was true in past years, especially with regard to mental subnormality. The younger the age on admission, the shorter is the stay. Readmissions to these special schools is rare, even though a third of the children discharged in the 1955-1960 survey still had four or five years of school life ahead of them. There is almost no follow-up information about the children reaching school-leaving age who were discharged with seizures uncontrolled (183).

Maladjusted

Maladjusted pupils are "pupils who show evidence of emotional instability or psychological disturbance and require special educational treatment in order to effect their personal, social or educational readjustment."

Another useful definition is that provided in the Underwood Report:

A child may be regarded as maladjusted who is developing in ways that have a bad effect upon himself or his fellows and cannot without help be remedied by his parents, teachers, or other adults in ordinary contact with him. It is characteristic of maladjusted children that they are insecure and unhappy and that they fail in their personal relationships (131).

The symptoms of maladjustment are as varied as the causes. Often the same symptom in two children has different causes, as in the case of bed-wetting which may have a physical cause or an emotional cause or a combination of the two. Symptoms are grouped in different ways to make reporting easier, as in this classification: (1) habit symptoms appearing in habits of feeding, sleeping, or toileting; (2) nervous symptoms of depression, hysteria, hyperactivity, or defiance; and (3) symptoms manifesting themselves only in a school setting, in a child's attitude toward a particular subject, or the teacher, or the total situation (131). One example of means developed for assisting the teacher to identify the maladjusted child are the Bristol Social Adjustment Guides, which are used in combination with the teacher's careful and objective record of the child's behavior.

In January 1964 the number of children requiring or receiving education at special schools for maladjusted children was nearly 7,000, but during the preceding year over 49,000 children had been treated at Child Guidance Clinics. Experts believe that thousands more could benefit from child guidance services if more clinics were available. It is difficult to get accurate estimates of the total number of maladjusted children in need of child guidance services with or without special educational treatment (131, 183). For one thing, there are too few skilled personnel to make the necessary surveys. For another thing, the term "maladjusted" is an administrative category classifying a child as maladjusted if he is considered to need special educational facilities. It is thus a narrower term than is usually implied, and includes only a small proportion of all emotionally disturbed children. As a result, estimates of the prevalence of "maladjustment" vary according to the number of special school places available (97).

There are 62 special schools for the maladjusted, of which most are residential—47 boarding schools, including 17 of secondary level, and 15 day schools, including one secondary school (186). Class size is limited to 15. The first school established by a local education authority for nervous and difficult children was a day school opened in Leicester in 1932 (189). The first day schools built specifically for maladjusted children since World War II were opened in Manchester and Coventry during 1965, and the construction of another in Southend was well advanced by the end of that year. Before this, such day schools had usually occupied buildings adapted for this purpose. The new Coventry School is designed to allow a few pupils to live as members of the headmaster's family. A new residential school for the maladjusted opened in Liverpool by the Secretary of State in December 1965 also takes some day pupils. Thus a maximum flexibility in meeting area needs is maintained. Special problems are faced in designing a building that is to be both home and school for the maladjusted, problems which are the subject of continuing consultation between local authorities and the Department of Education and Science (53).

The principles governing the education of maladjusted children are discussed in a 1965 publication of the Department of Education and Science (54). Although an increasing number of day schools is becoming available, there is continuing controversy as to the relative merits of these versus residential schools. One argument is that if the child's home has caused his maladjustment, the youngster attending the residential school must eventually return to the home that made his removal necessary in the first place. In the day school there is greater facility for treating the total problem in the family setting. The people serving the family can coordinate their efforts better than when the child attends a residential school because of

the short distances between home, school, and clinic. On the other hand, this arrangement is more feasible in cities than in rural areas. Also a child's attendance at a residential school may give him the strength and support which enable him to withstand his home environment when he returns (131). In some areas, however, a compromise arrangement between day and residential provision is found, consisting of an opportunity for maladjusted youngsters to live in hostels while attending a local day special school. This arrangement is preferred by the National Union of Teachers, which emphasizes the need for close cooperation between the headmaster of the special school and the warden of the hostel (274).

A youngster may stay in a special school for months or for years, depending on the seriousness of his problems and his response to treatment. Some children, particularly those from broken homes, may stay for four or five years. In some instances the discharge of the child also depends on the urgency of other cases awaiting admission to the special school, on the youngster's having reached the upper age limit for the school, or on the fitness of the home for receiving him (131). Successful adjustment as a basis for discharge is found difficult to assess, and there are few follow-up studies to provide relevant information. Thus reports may conflict in their findings. One report described the progress after periods ranging from three months to over a year for leavers from five London day schools for maladjusted youngsters. Of the 70 who had left to enter employment, 50 were in regular employment, whereas of the 24 sent to normal schools 10 had adjusted satisfactorily and 8 passably. In contrast another follow-up of 32 young people five years after leaving a special school for maladjusted children indicated that only five had made a good adjustment. Of course there is no evidence to suggest how much worse the behavior of the other 27 might have been if they had not attended the special school. There are also cases where the child's personality seems to resist all forms of treatment (131).

Voluntary organizations provide most of the schools for the maladjusted, such as the two schools established recently by the National Association for Mental Health for maladjusted boys and maladjusted girls respectively (233). Many local education authorities do not make provisions of their own for this group because of the shortage of trained personnel and also because there is no sense of urgency about the situation. These authorities pay fees for sending a few children from their area to a school for maladjusted children operated by another authority or by a voluntary agency (131).

There are more maladjusted children, and more girls proportionately, in non-maintained and independent schools than in maintained schools and hostels. The principle of coeducation is accepted, but where the schools are for children of secondary-school age, and the

total size of the school must be small, it is found difficult to provide satisfactory education for just a few girls (183).

The building program for 1965-66 to 1967-68 includes about £1.75 million for additional day and boarding school places for maladjusted children. Although the chief emphasis remains on the provision of places for boys, there are now more projects than before which either include places for girls or are exclusively for girls. Local education authorities in the eastern, southeastern, and metropolitan areas have agreed on the need for a boarding school for boys and girls with above-average intelligence whose emotional maladjustment makes it impossible for them to remain in regular schools, and the Essex education authority has agreed to provide this school. It will supplement provisions at the Red Hill School in East Sutton, Kent, a non-maintained special school for boys of grammar-school capacity.

Although some maladjusted youngsters need to attend a special day or residential school, efforts are made wherever possible to enable the child to live at home and attend a regular school while receiving treatment in one of the child guidance clinics which local education authorities are empowered to provide. These youngsters are differentiated from clearly psychotic children who need another form of special care. The first child guidance clinic to examine, diagnose, and generally to help children with emotional difficulties was opened in Birmingham in 1926. During 1964, 15 more child clinics were established in England and Wales, bringing the total to 325 (177).

One way of providing for maladjusted children in regular schools is to have a special class for them, a type of provision that is steadily increasing. In 1962 there were 763 pupils enrolled in 69 classes, as compared with 675 pupils and 54 classes in 1961 (176). London, with 25 day classes and 5 day schools, has led the country in the number and variety of places for maladjusted children. It is likely that in the future an important advance will be the establishment of more day classes as an essential part of the child guidance services; diagnosis in such a situation can be made with greater facility, and a sounder selection of children for placement in residential schools can be made. In addition the mixture of therapy and education is in itself what many maladjusted children require (183). The availability of such arrangements may help to remove the confusion between some categories of the maladjusted and the educationally subnormal in the thinking of parents and other lay persons, who fail to realize that while maladjusted children are nearly always "backward" in terms of educational achievement, backward children are by no means always maladjusted (7).

As in former years, the provision of adequate child-guidance services is limited by staffing difficulties. Although the number of

clinics provided by local education authorities steadily increased, the number of staff members has remained nearly the same. Comparative figures for December 1961 and December 1962, in terms of full-time equivalent numbers, are as follows:

Personnel	1961	1962
Psychiatrists	93	95
Educational psychologists	225	226
Psychiatric social workers	137	144

To help meet this shortage, an additional post-graduate course in educational psychology was started in 1963 at the University College of Swansea, bringing the total number of such approved courses to seven (177).

Psychotic

Educational opportunities for the more seriously disturbed children who are not included in the category of "maladjusted" are also increasingly available, usually in combination with some form of medical treatment, in contrast with their earlier relegation to mental hospitals with little or no opportunity for education as such. Awareness of their needs has arisen in part from the more accurate differentiation of these youngsters from those whose primary disability is of another type, as for example the educationally subnormal. It is possible that as their educability becomes more apparent, an official definition will be listed for them parallel to those for other categories of handicap.

Increased interest in the needs of such children was evident in parliamentary discussions and in the press during 1963. The Parliamentary Secretary gave an outline of existing and proposed provisions for the education and training of autistic children, stressing the need for close cooperation between the education and health services, and the development of experimental approaches (177). The report of a special committee appointed by a London hospital recommended the use of the term "schizophrenic syndrome in childhood" to refer to psychotic children so as to emphasize that psychosis is a mental illness and not merely a set of symptoms which sometimes complicate mental subnormality (183). This misconception is encouraged by the classification of mental illness and mental subnormality as parallel subdivisions under the general heading of the "mentally disordered."

A careful neurological, psychological, and educational investigation of the needs of the psychotic child is followed by a period of in-patient treatment in a psychiatric unit where such services are available. At some point special education is an important part of the program of therapy; the local education authority can arrange for part-time or full-time teaching for him in the hospital, or in a

special residential unit such as High Wick. A few special schools for educationally subnormal pupils have made successful provisions for psychotic youngsters when it has been possible to keep them in small groups. As a last resort, a child can receive instruction at home. Treatment results are unpredictable. Some can return to the regular school, others adjust satisfactorily in special schools, while still others may simply show arrested deterioration or some general improvement. Intellectual improvement is usually slow, perhaps because critical periods for learning were passed during the period of emotional disturbance, thus making further learning difficult or impossible. Although temporary exclusion from school or attendance at a training center might be necessary, the policy is usually to exclude the child from the educational system only when an exhaustive investigation and program of treatment has indicated that this is warranted (183).

As autistic children have become differentiated from mentally handicapped children in recent years, the parent-organized Society for Autistic Children has been active in their behalf. It is estimated that there are 5,000 such children in England and Wales, few of whom are receiving education adapted to their needs. For example, the Society found in a 1964 survey that only 14 out of a total of 239 autistic children were attending schools or classes especially for such children, while 130 others were in regular or special schools or hospital units where education was provided by local education authorities. The Department of Education and Science stated in late 1965 that less than a dozen local education authorities had made special provisions for autistic children but at least thirteen were planning units for them. In cooperation with the local authority at Richmond, Surrey, the Society for Autistic Children opened the first school for such children in the fall of 1965. But the Department's view is that many of these children are already suitably placed; there is as yet no agreement as to the best way to help autistic children, and separate units are not necessarily the answer. The Department called a conference on this question in November 1965 and then distributed copies of the proceedings to all chief education officers and principal school medical officers (305). Some experts contend that there is a very close similarity between the teaching of deaf, blind, and aphasic children and the teaching of autistic children.

Educationally Subnormal

Educationally subnormal pupils are "pupils who by reason of limited ability or other conditions resulting in educational retardation, require some specialised form of education wholly or partly in substitute for the education normally given in ordinary schools."

Three years after this official definition was provided in 1953 Ministry of Education regulations, a pamphlet from the Ministry

described ESN children as comprising between 5% and 10% of the school population who needed special help, and stated that most of them could and should be taught in regular schools. Attaching the label of educationally subnormal to such a large and varied group led to some confusion since, as the Ministry recognized, only a minority of them would be educated in ESN special schools; however, in a 1964 pamphlet, "Slow Learners at School," the Department of Education and Science pointed out that the term "slow learning" was now widely applied to children who were failing in school to some extent, and that the label ESN has become associated with "pronounced educational backwardness," with about 10% of all school children backward in language and number work (55). In other words, the 10% who are most backward in language and number work are to be referred to as "slow learning," and of that 10% only a small proportion suffering from pronounced educational backwardness are to be described as ESN (131). The numbers cited by local education authorities, however, indicate that more inclusive definitions are still being used in most areas.

The educationally subnormal are the largest group for whom the local education authority is obligated to provide special educational treatment. The 1956 Ministry of Education pamphlet had indicated that this group comprised between 5% and 10% of the school population who needed special help, and that most of them could and should be taught in regular schools. In 1960 this group of school children, according to another government report, totaled 47,247; the prevalence of ESN pupils per 1,000 school children rose from 5.1 in 1950 to 6.6 in 1960 (183). The number of ESN children attending *special* schools rose from 37,822 in 1963 to 40,921 in 1964 (177), and to 42,517 in 1965 (53). Such an increase of course reflected the availability of more places for such youngsters and correspondingly more accurate ascertainment of them, rather than any genuine increase in numbers.

Actual figures cited concerning the numbers of ESN vary from one area to another, this variation depending in part on methods of ascertainment and the definition used. For example, the Cheshire Education Committee refers to "dull" children rather than educationally subnormal pupils, and defines them in terms of an IQ range of 55 to 85. On this basis it was found that an average of 20% of the pupils in the secondary modern schools of Cheshire are dull, the percentage varying from 13% in one school to over 46% in another (31). The London County Council reported that in 1961 nearly half of all the handicapped children for whom it made special provision were educationally subnormal—4,086 out of a total of 8,878 (152). The increased attention that has been given in all areas of this group in recent years is shown by the fact that in all the issues of *Special Education* (this name for the *Special Schools*

Journal first appearing in May 1958) there have been more articles concerning the educationally subnormal than for any other group of handicapped youngsters. At the same time, the relative lateness of the emergence of special concern for this group as compared with other categories of handicap is indicated by the fact that 1950 marked the date both for the foundation of the National Society for Mentally Handicapped Children, and for the introduction of the first diploma course for experienced teachers of ESN children at the University of London's Institute for Education.

In 1963 there were 412 special schools for the educationally subnormal—288 day schools, including 36 of secondary level, and 124 residential schools, including 54 secondary schools (186). Adding to these the special provisions for them in regular schools, it is evident that the great majority continue to live at home while receiving their education. While new places have been added for the ESN at an average rate of about 2,000 a year, there are plans to increase the places more rapidly because of long waiting lists. The building program for 1965-66 and 1966-67 and the first part of 1967-68 is to provide about 6,600 additional special school places, bringing the total to over 55,000 (53, 177). One source states that while a total of nearly 52,000 children were either receiving special educational treatment or awaiting places for such treatment in 1964 the number still needing places was probably around 20,000 (131).

The kinds of provision made for ESN pupils vary from one authority to another. Though all-age schools predominate, day schools tend more and more to be provided for primary pupils, so that they can keep their home ties intact, whereas separate residential schools are more frequently provided for those of secondary-school age. Some stress provisions for boys and girls together, whereas others segregate them. Some authorities stress special classes in regular schools more than others do. The varying kinds of special treatment provided in regular schools consist of the following:

1. The single class—a special class, known as such, in the ordinary school.
2. Two special classes, each providing for two age groups only, in one school.
3. Transfer classes—a special class or classes set up in a conveniently located central school, used for special educational treatment by several schools which refer pupils there.
4. The multiple approach—inclusion in "D-stream" classes, perhaps with some special attention and supervision from a designated teacher (39).

There is much discussion about the relative advantages and disadvantages of these kinds of provisions. A Canadian psychologist,

in a letter to the editor of the *Times Educational Supplement*, asserted that no sweeping generalizations can be made about the advantages or disadvantages of special classes versus inclusion in the regular classroom; all one can say is that some special classes help some retarded children, and that if the retarded child is also mal-adjusted he is more likely to benefit from the special class (64). Other commentators have pointed out that sometimes the special class or the special school may become a refuge rather than a true educational center. But before the situation can be improved by moving the brighter ESN pupils to ordinary schools, there needs to be an adequate supply of sympathetic and suitably trained teachers in ordinary schools which have remedial departments that can diagnose and "cope with" ESN pupils (288). The final answer as to what constitutes suitable special educational treatment lies in the needs of each individual child (39).

An example of the kind of arrangements for ESN pupils preferred by a specific authority is that of Cornwall. Here an effort is made to avoid deliberate segregation of these youngsters, for they are included in "adjustment classes" in the regular school which are shared with other children with higher IQ's who have learning disabilities and sometimes emotional difficulties as well. Children who are transferred to another school for placement in an adjustment class usually remain in that school until they reach the age for transference to a secondary school, at which time they can be transferred to a normal class if they have shown sufficient progress. Parents' consent is obtained for the transfer to the special class, and while most parents cooperate willingly there are a few who react with suspicion and anger. Children are chosen for the adjustment classes by educational psychologists from the Schools' Psychological Service, who assess their social, emotional, and educational needs, and later check on their progress in the class. Priority in placement is given to those with the greatest intellectual handicap (389).

Considerable research and experimentation is being directed toward the improvement of instruction for ESN pupils. As an illustration, at Ashwood School, a special ESN school and assessment center, a small-scale experiment was devoted to assessing the usefulness of programmed instruction provided by the Oldborough Teaching Aid, a book-fed multiple-choice teaching aid serving to supplement normal classroom learning. Unanswered questions arising in connection with this experiment relate to the best ways to stimulate and maintain the interest of an ESN youngster in this type of learning situation, and the tremendous amount of time required when teachers devise special programs of this kind to meet individual needs (302).

Continuous improvements are being made in the curriculum of the schools for ESN youngsters as their needs are better understood.

A recent investigation of their reading difficulties indicates that, just as in the regular school, one finds in the ESN special school differences between poor readers and good readers which are related to differences in visual perception and spatial orientation, possibly neurological in origin. The study revealed no evidence of emotional disturbance as a cause of the reading differences in the 30 pairs of children considered, from three ESN day special schools (156).

A recent survey assessing the adequacy of physical-education programs in ESN schools educating boys of secondary age revealed an acute shortage of physical-education specialists who were willing to take up work with ESN children. In view of this fact, it was recommended that in the new ESN schools which are now rapidly appearing all over the country, money spent on gymnasiums might be wasted, and that heated indoor swimming pools could be substituted. Schools should concentrate on such activities as swimming, cross country running, and athletics consisting of simple repetitive actions or a series of such actions for which a special building, special apparatus, and special instruction would not be required as in the case of gymnastics (351).

Some local authorities provide for continuing education for the ESN school leaver as a practical application for the theoretical research of British psychologists which indicates that the mentally retarded learn over a longer span of time and may show considerable progress many years after the usual acquisition of intellectual skills has diminished. Classes for them give training in cookery, dress-making, metalwork, and woodwork in the evening. The ESN schools also serve them as social clubs providing games, music, and craft work. There are not only classes in craft work but also some classes in recreational evening institutes which are called general education classes for ESN youth and adults who want to continue their limited studies after leaving school (290).

While some educators believe that provisions for the ESN youngster are still very inadequate, others are encouraged by the experimentation being conducted, especially to meet the needs of ESN adolescents in the regular schools:

Perhaps the most inspiring development to me in this whole field has been seen in the formation of complete remedial departments under specially trained heads of departments in our large secondary modern and comprehensive schools (345).

The academic problems of ESN pupils, however, form only part of the total pattern of needs which school authorities are trying to meet. It has been the experience of the local education authority in Liverpool that in the ESN special school the changing of the youngster's attitudes toward school and life in general is of basic importance. He may be apathetic, inattentive, sullen, or assertive; he

is often convinced that he is a failure. Therefore what he needs is not more instruction but experiences that will give him the conviction that there is something he can really do in the world, that he need not always be a failure, and that he can learn after all. Handwork and housecraft have great therapeutic value because the youngster finds that he can make something which people need and appreciate, a fact that helps to develop his self respect. Emphasis is placed on a "normal" program including such activities as sports, physical education, dancing, swimming, and dramatic work. The special school aims to enable the youngster, by the time he leaves school, to read a newspaper or the lighter magazines, write a letter, fill out a form, use everyday arithmetic, and have a large fund of useful general knowledge (149).

Another problem occasionally faced by the Liverpool authority is parental reluctance about the child's attending a special school. Stress is now placed on the correct term "educationally subnormal" which emphasizes the child's educational needs, rather than the old term "mentally deficient" which formerly included all children with below-normal IQ's and focused attention on limited mental ability. The sending of youngsters with still lower IQ's to training centers rather than special schools helps to emphasize the distinction between being classified as ESN and as mentally subnormal, although this constitutes a disadvantage to the latter group of children which many educators believe is both unfortunate and unnecessary (149).

The sexual adjustments of ESN secondary pupils are often a matter of great concern. Though most adolescent homosexual experimentation represents a passing phase which is terminated by satisfactory relationships with the opposite sex leading to marriage, this solution is often less readily available to those of lower intelligence. There is unfortunately too much association, in the thinking of the layman, between subnormal intelligence and abnormal sex drives and a high incidence of sexual perversions, whereas the thousands of subnormal persons whose sex behavior does not lead to complaints are easily overlooked. Such abnormality as occurs, according to one authority, is due to arrested and incomplete emotional development.

The subnormal, having less ability to compensate and less resistance to temptation, sooner falls a victim to homosexual temptation, but the adoption of these practices cannot be held against him more than against a normal person (80).

More frequently today efforts are made in the school life of the ESN pupils, for example, to canalize sex urges rather than to build them up to explosive strength through repressive restrictions. Thus dances and social affairs, home visits for parties and games, and other opportunities for mixed activities, while presenting some problems for

direction and supervision, do tend to reduce more serious basic problems caused by stricter segregation (90). Many believe that more natural social opportunities are available for ESN pupils in regular schools than in residential special schools, whether mixed or segregated.

Some of the restrictive policies more widely adopted in the past have been due to assumptions about the undesirability of encouraging the person with lower intelligence to marry. But as one writer maintains:

The present tolerant arrangements regarding marriage must be continued until it is *proved* quite beyond reasonable doubt that such unions do indeed produce children of low mentality, or of lower mental ability than their parents. There is no justification for interfering *generally* with freedom unless there is good evidence that this would lead to undesirable results (80).

There is as yet uncertain genetic evidence and lack of agreement among genetic and social experts as to the biological results of marriage between subnormal persons.

Gunzburg, who has studied the problems of ESN school leavers who become social failures and in many cases are sent to mental institutions, has demonstrated that a carefully conceived and concentrated educational program within the institution can enable these young people to return successfully to community life and normal employment. In his book on "Social Rehabilitation of the Subnormal" he outlines what he calls an "educational first-aid scheme" to cover a period of from three to six months, which is geared to the practical demands of community life. Some of the minimum essentials to be included are telling time, using a telephone, using public transportation, rehearsing interviews and other situations, and finding an address. Among the adaptations for the subnormal girl is the inclusion of elementary cooking, with stress on cleanliness, possible dangers, planning meals, and basic methods used in food preparation; a set of recipes is worked out which covers routine skills using a single burner and the minimum of utensils. Some basic sewing skills are taught along with the use of scissors, a sewing machine, and an electric iron, with the purpose of producing simple garments which can be displayed or given away as the girl's own work (80).

Slow Learners

The blurring of the boundaries between the group called the educationally subnormal and other groups called "backward" or "slow learners" suggests the desirability of discussing the provisions for the low-achievement group on the secondary level, the "slow learners" in the C and D streams of the school system. Many so labelled

would once have been called educationally subnormal, as indicated in a 1964 Department of Education and Science publication called "Slow Learners at School" (55). Even where these slow learners are differentiated more specifically from the ESN in terms of IQ, their basic personal and academic problems are similar to those of ESN youth. The same general principles are involved in the education of the two groups, as suggested by the government publication.

Slow learners in the secondary modern school have a common characteristic of failure in reading with associated problems in other areas of learning. Motivation varies from apathy to persistent effort, in contrast to unfavorable public stereotypes. Home conditions as reflected in clothing vary from meticulous care to absolute rejection, and attitudes toward other children vary from automatic aggression to extreme withdrawal. Intelligence can range from low to superior. Since most experienced teachers with training in the teaching of reading are found in primary schools or in ESN special schools, remedial-reading posts have been created in secondary schools, along with "remedial departments" in the larger schools, to attract suitably trained teachers. Some local authorities offer the remedial services of their specialist teachers to other schools in the area, including secondary modern schools that have no remedial posts. The remedial teacher works in close cooperation with the head of the secondary school and his staff. This teacher gives standardized intelligence and achievement tests, interviews parents and children, compiles social and emotional profiles of problem children, and works out a remedial plan that involves as many of the staff as are willing to cooperate (343).

Methods of remedial education in secondary modern schools are as varied as the factors influencing failure in school—social, emotional, intellectual, educational, or health causes. A key emphasis is the establishing of a warm relationship between the youngster and a teacher who inspires trust and confidence in him so that he will want to try again. This is used as a basis for more specifically educational methods of helping the youth. The more intelligent backward children can be taught with the less intelligent until they begin to show a spurt in achievement. Minor maladjustments and behavior difficulties which often accompany educational retardation, whether as cause or effect, are treated through craftwork, drama, discussion group-work, and other techniques. It is considered important to establish personal contact with the youngster's parents in order to enlist their cooperation and help them to understand their child's needs. The British Broadcasting Company presents special radio programs for backward children which are often incorporated into school programs for these youngsters, with discussions, written work, reading, and drawing centered around the programs. A demonstration of the making of marionettes in a television show in one

instance led to a project involving a puppet theatre that could be used by groups of 6 or 7 children; the writing, producing, and rehearsing of plays for this theatre gave much practice in basic academic skills. Progressive local authorities encourage advances on a broad front, which constitutes not so much *special* educational treatment as *suitable* educational treatment. The old practice of giving the backward classes to the youngest teachers is rapidly disappearing, for it is recognized that teaching these children demands both personal maturity and professional skill.

A Rainsford County secondary school for girls demonstrates the importance of including for all the girls, whether in the C or D streams, special stress on subjects having a direct bearing on their personal and social life, such as good grooming, good manners, and adequate use of leisure time, which have also been emphasized in special-school provisions for ESN pupils (399).

The Cheshire Education Committee, which has published two lengthy reports on the education of the "dull" child at the primary stage and at the secondary stage, maintains that dull children (those with IQ's between 55 and 85) should in most cases be educated in ordinary schools, since their needs can be met there by having specially planned academic work under one teacher in a special class with a two-year age spread, and activities such as games, music, and art with the other children. The special residential schools are provided for those youngsters "who, in addition to low innate ability, are of such habits and behavior that their presence is detrimental to other children, or who have other problems of development, or difficulties of home background" (31).

Their report on the dull children at the secondary level describes in detail the usual characteristics of such a child when he moves into the secondary school. He is likely to have lost confidence in his own capacities and lacks persistence and concentration; as a result he may be either actively obstreperous or very quiet and apathetic. Uncertainty in the face of the unknown leads to anxiety and the blocking of the learning process. His home background may be poor. His leisure activities are limited. His emotional development is often slower than normal, and levels off at a lower point. He works better on things that are concrete, and his comprehension of speech is often slow. His muscular development and coordination may be poor. He responds more to the personality of the teacher than to subject matter, and he likes established routines. The dull girl is less able to control her awakening sex interests, and less able to express them in socially acceptable ways. Since the dull youngster often comes from a poor home where he has little help or advice in such matters, he is in particular need of assistance in matters of personal hygiene and sex, and in the development of sensible attitudes and behavior towards the opposite sex. This study describes the kind of academic

program which best meets the needs of dull adolescents, emphasizing the practical utility of the material they are taught.

An interesting three-year experiment in the social training of backward children was conducted at the Parson's Green School, a secondary modern school in southwest London with a high incidence of delinquency. The goal was to prevent the initial group of 30 D-stream boys with IQ's of about 80 from leaving school with a feeling of failure. They were to be shown other ways of gaining social approval than by passing examinations. By being encouraged to discuss and analyze their surroundings, starting with simple perception tests and progressing gradually to the dramatization of situations from everyday life, they gained self-respect and obtained insight into the behavior of other people. After six months there was a discussion as to how the boys could take a more positive part in the life of the school, and the boys suggested making hot drinks for pupils during breaks. From this canteen service they extended their help to community activities following suggestions from local social workers, such as helping lonely old-age pensioners and mending toys for kindergartens. Out of 200 boys who eventually participated in the program during the three-year period, only two got into trouble with the police; whereas in 1957 out of a class of 30 D-stream boys, 19 were brought before the courts, in a similar class of 32 boys in 1960 which had had the special training program only 2 came before the courts.

Word-Blind

A type of handicap closely related to school achievement which is being emphasized to an increasing extent is that of dyslexia or word blindness. School medical officers are giving increasing attention to reading difficulties since many of these are found to have a medical basis such as defects of hearing and vision (183).

The report on "Health of the School Child" (183) defines dyslexia as reading delay in a child of average intelligence without obvious physical or emotional handicap. Only when mental age has been established and is found to be considerably in advance of the reading is a child to be regarded as a case of reading delay. In general, the delay should amount to some three years or more before a diagnosis of dyslexia, as defined in this report, is justified. Of 225 examined in a survey by a Ministry of Education medical officer, a preliminary report in 1961 indicated that 19 had a physical defect (other than sensory) which did not include recognized cases of cerebral palsy; in some, cerebral palsy of a minimal degree was revealed for the first time. Also, 21 had sensory defects (12 vision and 9 hearing), which indicated that all delayed readers should have sight and hearing tests. In 35 cases there was limited intelligence. In 116 cases there were emotional factors, which represented the largest single group of defect associated with dyslexia; of these, 92 children had a history of

emotional symptoms arising before the sixth birthday. Speech defect was found in 39 cases, whereas 26 children had poor general memory function, though poor visual memory was less frequent than poor auditory memory. Defects of spatial concept were rare, contrary to some assumptions about the causes of reading delay.

The term "word blind" was used as early as 1878 to describe children who in spite of having normal intelligence and vision could not learn to read and spell. There is as yet disagreement as to its basic causes, as pointed out at a London conference on children with such problems arranged by the Invalid Children's Aid Association. It is still not clear whether the cause for dyslexia is basically organic or emotional, but there is some evidence that it is often hereditary, and occurs much more frequently in boys than in girls. Symptoms of dyslexia, as contrasted with poor reading in other youngsters, are wildly inaccurate, bizarre transposition of syllables, quite illogical spelling errors, complete misreading of words, and very cramped handwriting of variable direction. These children are often late talkers, unable to distinguish right from left and ambidextrous, but with no demonstrable brain disorder or defects of sight or hearing. Many have high intelligence and do mental arithmetic well. Screening of potentially word-blind children before entering school to make possible early special treatment is considered desirable. Patient individual instruction in school, using an alphabetic-phonetic method that emphasizes the sound and shape of letters and syllables, can bring about marked improvement. Even adolescents and adults can be treated through part-time courses. Word blindness is sometimes related to, and possibly causes, other problems, as indicated by the fact that whereas only 1% of London school children have serious reading difficulties, 10% of the children in "approved" schools (for delinquents) suffer from such difficulties (401).

Parents face the problem of getting effective help for their word-blind children. Help is now forthcoming from a new organization known as the Association for Helping Word-Blind Children. Also the Invalid Children's Aid Association plans to investigate the possibility of establishing centers in or near London for these children which could also be used as demonstration centers for teachers in training to serve such groups (401).

Speech Handicapped

Pupils with speech defects are "pupils who on account of defect or lack of speech not due to deafness require special educational treatment."

In general it is expected that up to 5% of all school children will need help with their speech. The need tends to decrease with age. Incidence is higher in special schools than in regular schools because of the frequent association of speech handicaps with other kinds of

disability. In the ESN special schools in one large city one in every seven children is being treated for speech problems, and even more would be treated if enough therapists were available. In schools for the physically handicapped many pupils, particularly those with cerebral palsy, have a speech handicap as well (131).

The classroom teacher can give help with minor problems such as slight faults in articulation, but most cases require the skilled assistance of a trained speech therapist, and some need in addition the combined skills of surgeons, orthodontists, and psychologists. The speech therapists may treat the child either in the school or at a local clinic, whichever is more convenient. Such treatment usually continues weekly for at least several months. In more difficult cases the youngster may be admitted to one of two special schools for children with speech defects: the John Horniman School at Worthing, Sussex, for juniors only; or the Moor House, Oxted, for both junior and senior children which has a diagnostic unit to which children can be sent for a thorough examination by a team of specialists. The child who needs help with his speech is usually referred by the teacher to the school medical officer, who may then arrange for the services of the speech therapist. There is still a shortage of these trained therapists, especially in the north and in the midland region (131).

The most common difficulty is faulty articulation. In cases where this persists beyond the point where one expects pronunciations to be mastered by the average child, as at age 7, various causes may be discovered such as poor hearing, a defect in the speech mechanisms, or the copying of poor speech models at home, and the nature of the treatment will depend on the basic cause. Stammering occurs in about 4% of all children below age 7, but the incidence in school children is closer to 1%, with more boys than girls experiencing this difficulty. Theories differ as to the importance of learning versus hereditary predispositions in analyzing possible causes. Cleft palates occur in one out of every 700 births, although the extent of the condition varies considerably from one child to another. In England, surgical and dental treatment during infancy and childhood will have markedly ameliorated most cases before the child ever reaches the school, so that speech therapy at that time will usually be focused on nasal speech (131).

There are some children, whose number is difficult to determine, whose speech difficulties need treatment from a psychologist more than from a speech therapist. Such children are variously labeled as schizophrenic, autistic, psychotic, or non-communicating. While many have common symptoms such as lack of awareness of others or withdrawal from them, there are many individual differences which call for individual methods of treatment. These children are found in the psychiatric units of hospitals, in regular schools, in

special schools, in training centers for subnormal children, and at home. The educational needs of autistic children have only recently come to the attention of the general public, partly through the efforts of the parents who have formed the organization called "The Society for Autistic Children" (131).

Homebound Children

The children who receive instruction at home usually fall into one of the following classifications:

1. Children who are convalescent or who have been recently discharged from the hospital, such as a child still in a plaster cast after a TB hip operation who is confined to bed but does not need continuous hospital treatment.
2. Severely chronically handicapped children such as those not expected to live beyond their early teens, in which cases the teacher may not only bring interest and pleasure into the child's life but may also give comfort and friendship to the parents.
3. Maladjusted children, whose maladjustment takes the form of timidity about leaving the parents or fear of the school situation, where it may seem desirable to permit the child to stay at home for a period while the teacher collaborates with the Child Guidance Clinic to continue his education and help him to adjust more satisfactorily.
4. Children whose classification is doubtful, such as a child who is a behavior problem at school, or a child about whom it is difficult to decide on optimum placement as in a training center versus a special school.
5. Children awaiting a special-school place or admission to a hospital, such as a child with multiple handicaps like educational subnormality with maladjustment, or epilepsy with an orthopedic handicap, who have been recommended for transfer to a special school but who have to wait till a vacancy occurs.
6. Children whose parents refuse placement in special schools, either because they feel stigma is attached to the placement or because the child would have to be sent to a distant residential school (131).

One survey of 512 home-taught children throughout Cheshire and Lancashire revealed that about 60% had more than one handicap, the most common defects being, in order of frequency, cerebral palsy, muscular dystrophy, severe emotional disturbance or psychosis, spina bifida, heart disease, epilepsy, paralysis from polio, and lung diseases (131).

The number of children being taught at home has risen steadily

during the past decade. The present incidence is about one in every 3,000 school children, or about 2,300 in a school population of seven million. It is believed, however, that the actual number who need home instruction is much larger. Some local education authorities have difficulty in providing home teachers for certain kinds of children, and in other instances children may be overlooked by the local authority because of inadequate liaison between hospital and education office or between welfare services and school. It is sometimes difficult to find teachers to serve in situations where the physical condition of the home is very poor or where parents are hostile and uncooperative. Youngsters needing secondary-level instruction often need the services of several specializing teachers rather than one home teacher (131).

Most home teachers serve on a part-time basis. They may combine their home teaching with hospital teaching or remedial work, but most of them are either regular teachers who add this assignment to their other duties by visiting homebound youngsters at the end of the school day, or part-time teachers paid by the hour. Some of these teachers have preschool children of their own whom they are able to leave for only the few hours of home instruction each day. Their ability to teach at odd hours during the day may make them more suitable for the teaching of young children, for whom the late-afternoon hours of regular teachers who come in at the end of their school day would be less desirable. Some married teachers are permitted to bring pupils into their own home for instruction. In other cases a teacher may save time by bringing several children together to form a single group in one home.

Teachers who spend most of their time in home teaching often complain of a sense of isolation and lack of contact with professional associates. In these cases a possible solution is to make a particular special school the base of operations for several home teachers, where they can get together to obtain their teaching supplies and discuss their problems (131).

The child being taught at home also faces the possibility of feeling isolated. The home teacher tries to keep the youngster in touch with other children and with the world outside the home as much as possible. She may arrange for the child occasionally to visit school functions, she may take him on visits outside the home, or she may encourage him to join a group such as Cubs or Brownies or an organization for persons with his kind of handicap. Members of this kind of association can be encouraged to visit him or write to him. In West Riding a magazine is produced specifically for home-taught children; it contains news, articles, and correspondence between the honorary editor and his readers (131).

In order for a child to be taught at home, the school medical officer must notify the local education authority about the child's need

for such teaching. The home teacher thereafter sends periodic reports concerning the child to the education office, which reviews each case and decides whether the instruction needs to be continued. The amount of instruction the child receives depends on factors such as his physical condition, his ability to profit from this teaching, and the amount of time the teacher can give him. The Department of Education and Science recommends that instruction should not exceed five sessions a week.

Hospital Patients

For youngsters confined to a hospital, instruction is provided which attempts to give as normal a program as physical disabilities and the demands of the hospital routine permit. Most of the hospital special schools in England and Wales — about 100 in all (27) — are maintained by local education authorities. When there is no hospital school as such, the authority may provide a teacher to give individual instruction where needed; sometimes these teachers are also giving home instruction to other children. The few hospital schools not under the control of local education authorities are operated by a variety of voluntary organizations, charitable or religious.

The teaching load varies from time to time in a particular hospital and also from one hospital to another. It will depend in part on the pattern of current discharges and admissions as well as on seasonal variations in the totals of accidents and illnesses. Because of frequent interruptions occasioned by hospital routine and treatment programs, the actual teaching time allotted to the youngster is much shorter than in the regular school. In the hospital setting children are more frequently grouped in terms of their ailments or the convenience of the medical consultant rather than in terms of age, sex, or ability. This can mean that in one instruction group there are children of all ages from 2 to 16, and that a teacher must either be able to cope with this wide age range or spend extra time walking from one ward to another to see youngsters of different ages (131).

In general hospitals the doctor's permission is usually necessary in order for a child to receive instruction. Whether or not he receives instruction also depends on his physical condition and on the estimated length of his hospital stay. In most orthopedic hospitals the incoming child is immediately registered for instruction since he is usually fit for such teaching on his arrival. Much patience and ingenuity are needed by the teacher in order to make up for the lack of customary classroom facilities, and to integrate this teaching with medical activities. The teacher must also be able to establish rapport quickly, to be content with achieving short-term goals, to encourage children to work independently, and to devise motivating techniques appropriate in a hospital situation where the usual pattern of incentives and competition is lacking (131).

In the Royal National Orthopaedic Hospital School near London, there is a special room for teaching the youngsters a "plan for living," for learning everyday social skills such as serving coffee. There is also a workshop with electrical equipment, in which students move from simpler to more complex operations, depending on their disabilities. The subject matter of their art work has been influenced recently by the rebuilding of Coventry Cathedral. Recreation can be participated in—even the "twist"!—in a wheelchair.* This particular hospital school has a total of over 100 patients ranging in age from 2 to 16 years, with a full-time teaching staff of 12 and a headmistress.

Where feasible, students are encouraged to prepare for a return to ordinary schools or to special schools for advanced work. Ingenious devices may enable them to compensate for the limitations imposed by a disability, as in the following example:

Ida, a polio patient from Mauritius, wanted to study for her Baccalaureate but was unable to turn the pages of her book. The problem was given to two technical engineers from the General Electric Company, Electronics Division, Stanmore, who designed a battery-operated page turner in their spare time which made all the difference to her studies and her morale (138).

As a result of medical advances and improved health services, the numbers served in hospital schools are decreasing, as is the average length of stay for youngsters in the hospital. Early hospital schools were provided primarily in long-stay hospitals for children with rheumatic fever or tuberculosis. However, as the medical staff became aware of the important part education might play in the hospital routine, and the 1944 Education Act empowered local authorities to establish hospital schools where feasible, such schools were extended to general hospitals and short-stay patients. Although staff shortages made it impossible for all local authorities to provide hospital schools, the service reached its peak in 1954 when 6,671 children received education in such schools and an additional group of between 1,000 and 2,000 youngsters were taught individually in hospitals (138).

The hospital school meets a variety of needs. A shy youngster may do better academically in this setting because of the individual attention he receives. Such personal attention is especially helpful for students preparing for examinations; contact is maintained with the regular school, whose syllabus is followed in the hospital school program. The schoolwork itself may serve therapeutic purposes as in the case of compositions that provide an outlet for tension or a means for expressing gratitude. The teacher can also provide continuing

* Interview with Miss Charlotte MacPherson, then Headmistress of the School, at the Second International Seminar on Special Education, Nyborg, Denmark, June, 1963.

emotional support after the youngster leaves the hospital, as in the case of a teen-age boy who enjoyed his hospital lessons so much that while convalescing at home he returned to the hospital daily, and thus relieved the anxiety he felt about returning to the regular school (138). Although staff shortages, inadequate quarters, and a tendency to regard teachers as intruders in the hospital routine may occasionally present problems, the adolescent patient is usually enabled to continue his education satisfactorily while away from his normal classmates.

THE YOUTH SERVICE

The Youth Service is provided under the Department of Education and Science. The handicapped adolescent can often participate in its program along with other school leavers 15 to 20 years of age.* The Youth Service generally includes statutory and voluntary efforts to provide young people with informal education, social intercourse, and creative use of leisure time through membership in a group (93). Up until the time of the first World War the provision of recreational opportunities for young people lay largely in the hands of voluntary societies. The increase in juvenile delinquency during that war led to the formation of youth committees made up of members of public and private agencies. A National Youth Committee was established in 1939, and the local education authorities were subsequently urged to form youth committees of their own. However, it was not until the passage of the Education Act, 1944, that the Youth Service became part of a comprehensive system of further education in which it was the duty of the local education authority to provide part-time and full-time education for youth over compulsory school age, as well as leisure-time occupations for them (93).

In Great Britain in 1965 there were 234,508 members, 86% of them in the age range of 14 to 20, in 3,244 clubs, of which 3,123 were for mixed membership and 121 for girls alone. Subtracting the figures for Northern Ireland and Scotland, the data for England and Wales alone are 218,246 members in 2,963 clubs, of which 82 are for girls alone (252).

The Albemarle committee report defined the function of the Youth Service as follows:

To encourage young people to come together into groups of their own choosing is the fundamental task of the Service. Their social needs must be met before their needs for training and formal instruction (193).

Thus the youth clubs aim to ease the transition between school life and life as an adult citizen in the community.

* Uniformed organizations are popular with boys and girls below school-leaving age. The most popular of these are the Boys Scouts Association and the Girl Guides Association, which in 1963 had a United Kingdom membership of 507,946 and 543,045 respectively (27). In some communities there are special groups of this kind for handicapped youngsters, whereas in other instances handicapped children are included with normal youngsters.

The National College for the Training of Youth Leaders has a one-year course established in 1961, which by the fall of 1964 had trained a total of 342 men and women for full-time work, of whom 88% are still in the Youth Service. There is some concern because to date only 23% of the persons training have been women; the Youth Service may be too dependent on men for its personnel (353).

By the end of 1965 a total of 1,287 persons were registered with the Department of Education and Science as full-time youth leaders. The fifth session at the National College that year enrolled 140 students (122 men and 18 women), while there were 78 students in training at the four other recognized courses for full-time youth leaders. The Department announced its plans to sponsor a residential course at the National College in 1966 for youth leaders already in service (53).

The work of the Youth Service is aided considerably by voluntary organizations. The National Council of Social Service, in its 1961-62 annual report, stated that the 1960 membership figures for the national voluntary youth organizations had recorded an approximate total of over 200,000 voluntary leaders in the United Kingdom (255).

The chief provision for the handicapped made by the National Association of Youth Clubs is a week-long Treasure Trove Summer School provided in various parts of the country for handicapped youth chiefly between the ages of 16 and 21. Each summer school consists of a group of between 25 to 35 handicapped persons, depending on the accommodations available, and about the same number of club member helpers who give up a week's vacation time to work and live with the handicapped in these sessions. The initial experimental program was offered in Hampshire in 1958. Eight such courses were planned for the summer of 1964.

The purpose of such a program is stated in the brochure describing the Treasure Trove School at Elfinward, Harwards Heath, Sussex, July 13-20, 1963:

It is designed to give young people the opportunity to share and learn more about common interests and to meet other young people from different parts of the British Isles. The mornings will be spent working together at a chosen interest and the afternoon and evening programs give an opportunity for outdoor activities, social events and exploration of the neighborhood (253).

The program included art, drama, music, swimming, photography, archery, tennis, and local studies.

The Townsend Club, established in Bristol in 1960, was the first youth club to be set up specifically for mentally retarded young people. It has proved very successful. Membership is open to all mentally handicapped persons over the age of 16 living in Bristol

or the district. After the first year of operation it had a membership of 87. The club is open three evenings a week from 7 to 9. Activities include leatherwork, knitting and sewing, physical education, painting, country dancing, old-time dancing and jive, as well as other indoor and outdoor activities. The Health Committee of Bristol provides transportation for those boys and girls unable to travel to the club by public transportation. The club is affiliated with the National Association of Boy Scouts and the National Association of Youth Clubs (with mixed membership).

More youth clubs are needed for the ESN school leaver, according to a recent survey of 361 ESN secondary schools, both day and residential. In most of the residential schools youth activities are still provided as part of the regular school life, though this has the disadvantage of isolating the young people from the mainstream of community life. Questionnaire replies indicated much interest in the formation of youth clubs, and the desire for help in organizing them. Various methods have been evolved for organizing such ESN Youth Clubs:

1. Clubs organized on the school premises with a staff member acting as leader, and membership either confined to pupils or ex-pupils of the school, or allowing a certain percentage of regular non-ESN members.
2. Clubs organized off the school premises but with a member of the school staff acting as leader, again with the two types of membership.
3. No special club but with ESN youth attending local youth clubs guided by the local Youth Officer working in cooperation with the school.

In every instance the chief responsibility for youth work for the ESN youngsters rested with the school concerned, although there appeared to be little special provision for staffing and facilities. The schools need more help in assuming this responsibility. Although opinions stated in the questionnaires differed as to whether clubs should include both sexes, most schools favored mixed groups where adequate supervision could be provided. Clubs appeared to be more successful when the leader was a member of the school staff and therefore had a better understanding of ESN youth. Their special needs are not always recognized by the local education authority.

Suggestions were made as to more adequate training for leaders, better facilities, increased financial aid, and liaison with other social and welfare services for the handicapped youngster. It was concluded that an ideal arrangement would be a mixed club combining ESN and non-ESN young people, enjoying activities such as sports, crafts, and summer programs of camping, canoeing, and field trips (284).

Youth clubs for mentally handicapped youngsters, including the more severely handicapped, have been established by the National Society for Mentally Handicapped Children, often in cooperation with regular Youth Clubs and social welfare organizations such as the Red Cross and Rotary Clubs. Since these projects sometimes entail transportation problems, some local affiliates of the society have raised funds to purchase small buses for this purpose (267).

There has been some disagreement as to both the aims and the effects of the youth clubs. Some commentators have gone so far as to assert that they encourage youthful immaturity, lead to the disintegration of family life, and hinder the natural transition from childhood to the adult community, whereas others have insisted that the adolescent needs both the close association with the adult community and the chance to withdraw from it at times (93). However, the consensus of attitudes toward youth clubs has been favorable, as indicated by the action taken in 1960 by the Ministry of Education to form a Youth Service Development Council to supervise a ten-year development program of youth services (93). In the period 1963-64 a £14 million building program for the youth service was undertaken; also the training of full-time youth leaders was speeded up, and the training of part-time leaders was recommended (176). A monthly journal called *Youth Service* in 1965 had a circulation of over 24,000 (53).

The handicapped adolescent can thus enjoy the benefits either of social clubs organized specifically for him, or of clubs organized for youth without reference to handicaps. Many parents feel that the latter kind of youth club should do more to make handicapped youth feel welcome (97). A Working Party set up in October 1959 by the Council of the British Psychological Society recommended that encouragement be given, both locally and nationally, to the Youth Service to extend its work to include handicapped school leavers.

Chapter 3.

Vocational Assessment, Guidance, and Placement Services

THE YOUTH EMPLOYMENT SERVICE

The principal official agency assisting both normal and handicapped school leavers to find jobs is the Youth Employment Service. This service, through interviews with pupils before they leave school, cooperation with those providing guidance in the regular and special schools, and contacts with potential employers in industry, helps the young person to find employment related to his preferences and capacities (114). It represents a form of collaboration between the Ministry of Labour and local education authorities in assuming responsibility for handicapped youth as well as the non-handicapped.

Acceptance of the principle of free compulsory education led logically to helping youth to prepare for the world of work after leaving school. This came to mean help in finding a job best suited to an individual's aptitudes and abilities, and protection from exploitation and injury. The acceptance of this philosophy was a part of the trend toward the welfare state with its broadened concept of meeting the physical and social needs of youngsters in addition to educating them.

The Youth Employment Service had its origin in the Labour Exchanges Act, 1909, which led to the establishment by the Board of Trade of employment exchanges which were primarily for adults but which often included juvenile departments. Specific provision for young people was made in the following year, when the Education (Choice of Employment) Act, 1910, empowered local education authorities to advise boys and girls under 17 as to the choice of a career. Many authorities had already set up juvenile employment bureaus at that time. The "Juvenile Employment Service" became the "Youth Employment Service" in 1948.

Local education authorities have the option of deciding whether they wish to operate their own youth employment service or if they

prefer to have the Ministry of Labour provide this service through the local employment exchanges. If a local authority does decide to provide the service, it must be approved by the Ministry of Labour, which gives a 75% subsidy for the cost of the service (93). Of the 1,500 youth employment officers now in service, about 1,300 are appointed by local authorities (376). The objective of both local and Ministry types of service is identical — to help the adolescent to choose, find, and become happily settled in a job suited to his capacities.

Each of the two alternative types of youth employment service has its own problems. Where the Ministry of Labour provides the Youth Employment Service, effective contact with the schools and with the local education authority must depend on the initiative of its youth employment officers and on the response to this initiative. Where the local authority provides the service, the crucial point comes when it is time to hand over cases to the Ministry, which is alone responsible for employment work with adults. The transition here is smoothest when there is a close and cordial relationship between the two sets of officers, and when the local authority has not hesitated to use, when needed, services provided by the Ministry of Labour which are outside its own scope. But in the Ministry's Youth Employment Service there is no specialist assigned to work exclusively with handicapped people, as is found in some local services. This is in line with the policy of the Central Youth Employment Executive (directly under the Ministry of Labour) to treat the handicapped as much like normal people as possible. It is recognized that handicapped cases take much more time and care than normal cases, which necessitates a reduction in the case-load of the specialized youth employment officer. Since some officers in the Ministry service have demonstrated a special flair for working with handicapped youth, arrangements are made to enable them to work with individual cases presenting special difficulty (286).

The youth employment officer has the responsibility of visiting every school, regular or special, to have a job counselling conference with each youth who will be leaving that year, as well as with the parents and headmaster if possible. They discuss the pupil's vocational preferences and capacities, the opportunities for employment, and any special problems which may be faced in choosing and finding a job. Such a conference is scheduled early in the school year. This is done to allow time to investigate the possibilities of further training and rehabilitation if these seem desirable. An early conference is especially important for handicapped pupils who attend residential special schools some distance from the home community in which they hope to find a job. In this case the youth employment officer serving the school sends his information about the pupil to the youth employment officer in the youngster's home area (93). The officer is

urged to be on the lookout for handicapped youth attending regular schools, since they represent about 10% of the total.

The pattern of vocational guidance provided by a local Youth Employment Service must conform to a Model Scheme which specifies the personal interview with the school leaver, provision of information to him about different kinds of employment, and a summarizing record of his health, aptitudes, and scholastic achievements. Information is usually given in talks by the officer himself or by workers in particular occupations, as well as through careers booklets or occupational leaflets (93). These may be supplemented by films or factory visits. Some firms, in collaboration with the Youth Employment Service, offer "Adjustment to Industry" courses in the school which give young people a picture of the new world of work they are entering, with information about national insurance, trades unions, working conditions, and the like (7).

In making his assessment of the capacities of the youth he interviews, the young employment officer has various sources of information at his disposal. The careers master (guidance counsellor) of the school usually cooperates closely (51). In assessing the background potentialities and desires of pupils, he may be better able to make judgments than an interviewing employment officer because of his more intimate knowledge of the pupils over a longer period of time. Careers masters are not found even in every regular school, however, in spite of the fact that they increased by 48% between 1956 and 1961, and they are still seldom found in special schools.

Youth employment officers also work closely with almoners (social workers), who have valuable background information about the home. Advice from the ophthalmologist or psychologist is also available. Schools are required to provide the officers with reports on the school leaver's health and physique, his educational attainments, his general ability, and his special aptitudes (10). Since many handicapped youth stay in school past the statutory age, the youth employment officer depends on the schools to provide reports on them voluntarily. His work thus represents the cooperation of many persons, including the teacher, therapists, and the school medical officer.

As a matter of policy, the youth employment officer will not recommend specific occupations for particular handicaps, such as linotype operator for the deaf. Personal qualities such as intellectual capacity and emotional stability are regarded as much more significant in determining suitability for various types of jobs. The confidential school medical record is very important to the youth employment officer in assessing the capacities of handicapped youth. For example, in the case of epileptics it provides information on the nature and frequency of attacks, their after-effects, time of occurrence (night or day), and presence of a warning aura. The officer takes into account any limitations on activity mentioned in the medical record.

Three forms are used at present for the confidential report sent by the school medical officer to the youth employment officer: (1) a general routine report form used for all school leavers, with basic personal information, a list of 17 occupations for which the individual concerned may not be considered suitable, and space for other comments from the officer; (2) a special form for the handicapped youngster, similar to the general form but including the nature of the disability and the parents' signed consent to the sending of the report to the youth employment officer; and (3) a school report form with a simple summary of school achievement and such assessment of ability and aptitude as has been possible in school.

For handicapped school leavers, the youth employment officer finds the second form most useful. But some criticisms have been offered concerning this form. The requirement of the parents' signature means the possibility of withholding vital information from the youth employment officer. Also some medical officers are reluctant to place information about a disability in non-medical hands, even in confidence, as for example in the case of epilepsy. The British Council for Rehabilitation of the Disabled has recommended that all information be made available to the youth employment officer and that parental consent be stipulated only for giving such information to employers and others. Another criticism is that the occupations indicated as unsuitable for the child are described in such general terms that they may have little meaning in the case of a particular child. For these reasons many local education authorities are dissatisfied with the first two forms, and prefer to use forms of their own devising (10). The British Council for Rehabilitation further recommended that the present form be replaced by a medical report form based on a functional assessment of disability.*

In summarizing his information about a youngster, the youth employment officer normally uses the "Seven Point Plan" developed by the National Institute of Industrial Psychology as a framework to help him determine whether all relevant considerations have been taken into account as a basis for his recommendations. The seven headings of the plan are (1) health and physique; (2) educational attainments; (3) general ability (or general intelligence); (4) specialized aptitudes; (5) disposition; (6) interests; and (7) any special personal or domestic circumstances. The detailed interpretation and application of these points are explained in material sent to the youth employment officer by the Central Youth Employment Executive. The school keeps a record of the recommendation made by the officer for a particular child, and his parents may see this card, though neither they nor the youngster need follow the recommendation (10).

* Appendix 5 of the report of the Working Party of the Council gives a suggested form for such an assessment drawn up by a sub-committee appointed for this purpose (10).

Once a handicapped youngster is placed in employment, the youth employment officer during the critical first few weeks tries to maintain a close liaison with the employer and with the youngster to see that a good initial adjustment is achieved. To the extent that his time permits, he also tries to keep informed about the progress of all handicapped young people at work until they reach the age of 18. In this task he is sometimes aided by the follow-up surveys made by some special schools of their former pupils, as in the case of a school in the Midlands that followed up in detail about 200 of its educationally subnormal school leavers, a high proportion of whom had made an inadequate adjustment. This school then in consultation with the youth employment officer revised its program to prepare the pupils more carefully and more directly for the transition period when they moved from school to work (51).

Recent recommendations have been that (1) youth employment officers be appointed whose sole responsibility is for serving handicapped school leavers, especially in urban areas such as London and Liverpool (where such specialists are already found); and (2) where this provision is not feasible, youth employment officers be given more advice and support from educational and vocational psychologists (10). Such specialized service is to some extent available from the Industrial Rehabilitation Units of the Ministry of Labour (to be discussed in the next section), which admit disabled young people either for a normal course of several weeks' duration or for a short assessment period lasting up to five days. Since there appears to be a potential demand for these Industrial Rehabilitation Unit services far in excess of the facilities provided, and since half of the urban population lives outside the areas served by the IRU's, there is obviously a need for more technical support. As a matter of fact, according to evidence furnished to a special committee of the British Council for Rehabilitation of the Disabled, the specialist services in such units deal in all with only about 0.2% of the young people assisted by the youth employment officers or about one in every 450, in contrast to one in ten who get such services in many European countries. This report further stated that Great Britain lacked properly staffed vocational guidance services to a greater extent than some other European countries (10). Probably the Scandinavian countries were represented in this "some."

There is difference of opinion as to how the specialist advisory officer can best serve handicapped young people. In one area the officer is given the opportunity to advise and place in employment all handicapped school leavers in the area. In other areas this responsibility is shared by all the youth employment officers as part of their regular case load, though they may consult with their specialist colleague who may, or may not, have a case load of his own. The latter arrangement was recommended by the committee, as it avoided

completely separate provision for the handicapped. The committee also recommended courses of training for youth employment officers specializing in the needs of handicapped school leavers (10).

London is one of the cities which provide a special youth employment officer to serve the handicapped. The close cooperation between the local education authority and the Youth Employment Service assures better service to both normal and handicapped youth. Careers talks are given at an earlier point now than heretofore in the youngster's program — sometimes at the beginning of the last school year, and in some schools as early as the third-form level (three years before leaving school). These talks usually follow parent meetings addressed by the head of the school or a member of the staff, and by the youth employment officer. At the end of the careers talks, pupils are now given printed summaries to take home and discuss with their parents. There are many of these careers talks, because of the variety of occupations represented and the varying needs of the students themselves. A London County Council report stated that the total number of such talks was 801 in 1958, 870 in 1959, and 971 in 1960 (151).

Another service is that of Careers Conventions, evening meetings of pupils of upper schools and their parents, at which up to 50 representatives of industry, commerce, and the professions are present to answer specific questions about careers with which they are concerned. Also in 1959 an experiment was initiated for offering "adjustment to work" courses for pupils leaving school at age 15. Topics included job prospects, the right attitude toward work, methods of applying for a job, ways of conducting themselves during interviews, and the budgeting of wages. In 1960-61, a total of 1,655 handicapped young persons (1,003 boys and 652 girls) were assisted by the Youth Employment Service (151).

The special youth employment services provided by the London County Council are linked with the authority's 17 special schools and with some 50 additional special schools under voluntary management to which handicapped children are also sent. About 15% of the children listed as handicapped are in the regular schools. There are 19 local youth employment committees, with their own offices and bureaus, and most of them have a sub-committee for the handicapped. The most difficult cases, including the partially sighted, are handled by the central office, which has a handicapped persons' section with its own staff. Full use is also made of voluntary facilities. There are interviews each term at the special schools, for prospective school leavers, which both parents are invited to attend. The number on the "active register" of those receiving special assistance, including follow-up after placing, is about 1,700 (286).

Liverpool is another city which provides special employment services for handicapped youth. A mutually cooperative relationship

exists between the Youth Employment Service and the School Health Service and the staffs of special schools. Regular case conferences are held in all the special schools in order to pool resources before attempting to place school leavers in employment. Parents are invited to participate in these conferences. There is also close co-operation with the city hospital almoners so that any necessary medical information can be obtained, and if desirable, boys and girls can be seen in the hospital when their treatment is nearing completion in order to discuss plans for future employment or training. A few severely disabled young people unable to use normal transportation facilities are visited in their homes; in one year 135 home visits were made chiefly for purposes of after-care or to obtain the cooperation of parents.

In the same year, 604 young persons (347 boys and 257 girls) with either physical or mental handicaps were dealt with in the Handicapped Section of the Youth Employment Bureau. Of these, 230 boys and 176 girls had left directly from special schools. Although the remaining 198 had completed their education in some other kind of school, many of them had spent part of their life as special-school pupils. The largest groups of handicaps were the following:

Educationally subnormal	303
Asthma and bronchitis	56
Epilepsy	39
Deafness	28
Amputations, deformities, and injuries..	27
Cerebral palsy	19

Some of these youngsters were particularly limited in their choice of employment because of their multiple handicaps, such as epilepsy with spastic paralysis or physical disabilities with mental subnormality. A large number each year are found incapable of holding regular jobs, and yet cannot be placed in sheltered employment because the local facilities are so limited. Increased numbers of ESN youth are attending the Mental Health Service's training center because more places are now available, and also because it is often difficult for the retarded youngster to find a job (149).

Leicestershire has also instituted a special program of assessment and placement to help handicapped school leavers. A committee was formed in 1960 to consider each case individually. The medical officer of health, an educational welfare officer, the headmaster of a special school, and the county's youth employment officer confer three times a year, emphasizing the school leaver's ability rather than his limitations. Between 30 and 40 cases are considered at each meeting, and reports on these individuals are sent to area youth employment officers. In many cases welfare officers must visit the handicapped pupils in their homes when domestic problems must be solved before jobs

can be arranged. The county youth employment officer reports that though they are not 100% successful in placing handicapped youth, employers have been cooperative and results are promising. The special committee handles the educationally subnormal, spastics, those with poor eyesight, heart cases, epileptics, and youth with chest diseases, muscular disorders, skin complaints, and a variety of tubercular conditions (98).

Unlike London, Leicester, and Liverpool, the Birmingham education authority prefers as a matter of policy that handicapped youth be dealt with by their five district youth employment officers, who work as a team. Direct contact is maintained with the headmaster or careers master of both regular and special schools, and cases of handicapped children are referred to the youth employment officer. Full use is made of voluntary organizations, especially the Co-ordinating Committee and the Fellowship of the Handicapped. At the upper age limit, cases are passed on personally by the youth employment officers to Ministry of Labour officials in adult service programs. The Ministry's rehabilitation unit at Handsworth is freely used, but there is said to be reluctance to accept cases there under age 16. In particular, the three-day assessment courses at Handsworth are found useful for difficult cases such as those where there is a combination of physical and mental handicaps (286).

The city of Birmingham, incidentally, was a pioneer in exploring the possibilities of scientific vocational guidance. In a 1924 program of experimentation in cooperation with the National Institute of Industrial Psychology, more favorable employment records resulted for those children who received and used such scientific guidance. Experience in Birmingham has demonstrated that the functions of the youth employment officer are facilitated if local authorities and special schools have well organized programs for vocational assessment and guidance followed by job placement (286).

As in the case of Birmingham, it is a matter of policy in Manchester not to have a special youth employment officer for the handicapped (286). In addition to four district officers, there are two special officers who interview employers. Children in special schools are reported two years before leaving, with a recommendation as to what kinds of employment are not suitable, and hospital almoners report cases of young persons about to be discharged. Heads of the special schools attend bimonthly meetings of the After-Care Committee that follows up school leavers when they become employed.

Efforts are being made in all areas to expand the services provided for handicapped youth by the Youth Employment Service, especially in preparation for various professions. The service not only informs young disabled people about professional opportunities but also helps them to acquire the necessary training, as for medicine and accounting. It pays for the training but does not provide the training itself;

the professional training program that enables the blind to become physiotherapists is the only one provided specifically for a group of the handicapped. Usually the handicapped youth apply on their own and make their own arrangements, although they might come to a Ministry of Labour official beforehand for advice. The Ministry pays them training allowances in professional preparation just as it does other trainees. If the profession requires a university degree, the decision to subsidize this kind of preparation in an individual case might be made by the Disabled Persons Department in the Ministry of Labour, or referred to the Ministry of Education. About 30 handicapped youngsters a year take advantage of this provision.*

Follow-up programs (called "after-care") have also been attempted by some authorities. Such service is of particular importance to handicapped youth, in view of the more complex employment adjustments which many of them face. In many instances the officer works with the Appointed Factory Doctor, as discussed in a later section of this report, though this kind of cooperation needs to be extended markedly (113, 208). Handicapped youth can share with normal youth the "Open Evenings" which young workers are invited to attend, where they can discuss their work and prospects with youth employment officers and members of the local after-care committee, when such a committee exists as in London. Suggested additional forms of follow-up which would be especially helpful to handicapped school leavers are home visits and contacts with employers and youth workers. The aim is to get the young person to regard youth employment officers as "experienced and understanding friends to whom he can turn for counsel and guidance about his employment, who will encourage and advise him if he wishes to better himself, or, if he is unhappy or unsuccessful in his first choice, will give him further help and guidance until he is suitably placed, and can make his own way in the world" (93).

The need for follow-up of handicapped youngsters after placement is widely recognized. A typical statement is the following:

The progress of disabled young workers should be closely followed, preferably through visits to their places of work, particularly if they are blind, deaf or in any other way seriously limited. Parents must be kept in the picture. Trained at school to make light of their disabilities, handicapped leavers aim to become independent and it is satisfying that, with the right help, as many as 97% can succeed in becoming working members of the community (47).

Examples of the after-care follow-up services for handicapped youth are found in the section on "Employment."

The importance of the youth employment officer's role is indicated

* Interview with Mr. S. Goldblatt, Disabled Persons Department, Ministry of Labour, July 1963.

by increased emphasis on the need for specific training. Although in the past employment officers received chiefly on-the-job training, the Ministry of Labour no longer regards this as sufficient for its own officers. All the Ministry employment officers get 12 weeks of training, which includes an initial week working with a regional officer, four weeks observing employment officers in action, a four-week course at Birkbeck College in London, a two-week follow-up course, and a year later a further week's guidance on the job. Oxford and the Manchester College of Commerce each offers a longer course for recruits—six months for graduates and ten months for others. Already over a third of the officers appointed by local education authorities are trained persons (376). A continuing concern, however, is that not all the places in the recently expanded training facilities are being filled, at a time when the need for specialized training is generally recognized (384). It is hoped that further refinements in such training will eliminate a common criticism that although the term V.G.O. (Vocational Guidance Officer) is frequently used in the Youth Employment Service, the vocational guidance element in the training of such officers has often been minimal.

There are many problems faced by the youth employment officer in fulfilling his expanding responsibilities, some relating to work with all school leavers and other problems specific to his work with handicapped youth. One problem is that of keeping adequately informed concerning the employment conditions and opportunities in his area. He must not only have information about the local labor market, but he must also be acquainted with those members of firms who are concerned with the training and supervision of new entrants (47). He does have the opportunity to keep in touch with local arrangements for training in employment, through attendance at meetings of Local Joint Apprenticeship Committees (10). Nevertheless it is often difficult for the officer to have complete details about the local job situation, and to have sufficient knowledge about all the kinds of work involved to counsel the young person accurately.

Such counselling is complicated by the need to be alert to the conditions of work in which young people are to be placed, and the extent to which firms abide by legislative provisions designed to protect young workers. For example, the Shops Act, 1934, the Young Persons (Employment) Act, 1938, and the Shops Act, 1950, all restricted the working hours of young people. The Factories Acts of 1937, 1948, and 1959 all protected the young worker along with workers in general; the 1937 Act prohibited young people from operating certain kinds of dangerous machines, and the later acts increased the scope of the occupations covered by restrictive legislation (93).

The situation is even more complicated for the youth employment officer in some localities (as in mining sections and rural areas)

where there is little variety in the types of occupation available for young people (93). Although there is some financial assistance for those who wish to transfer to areas with order opportunities, in actual practice it is often found that both the young persons and their parents are unwilling to consider job prospects that entail their leaving home. This is especially true in the case of handicapped youngsters, for whom suitable living accommodations in another community would be more difficult to find, or who have become dependent on their home for physical care or emotional support.

Another problem is seeing that the youth employment services provided are fully used by employers and by young people seeking work. Employers are not compelled to notify the officer concerning vacancies, nor is the young person compelled to use his services. Thus the youth employment officer does not always know what job openings are available or what youngsters are looking for work. The extent to which young people and potential employers request his help depends not only on his efficiency in job placement and his understanding and sympathy, but also on environmental factors beyond his control, such as local employment traditions and opportunities, and the effect of increasing numbers of school leavers seeking work (93). It is interesting to find many young handicapped persons who feel, along with their parents, that seeking the help of the youth employment officer is an admission of weakness, an indication of helplessness and defeat; often they prefer to approach friends and relatives for employment suggestions and assistance.

If the Youth Employment Service is to provide effective help for handicapped adolescents in finding jobs, a more accurate concept of the dimensions of the need in terms of the number requiring such help should be available. But estimates of the number of handicapped adolescents leaving school each year vary. A 1960 Ministry of Labour inquiry concluded that in Great Britain as a whole "upwards of 20,000 handicapped boys and girls leave school annually" (209). In contrast, one writer in 1963 reported that approximately 10,000 handicapped school leavers need help each year in finding jobs (95). Neither the difference in date nor the area covered can adequately account for the difference in estimates.

It is also difficult for the youth employment officer to make an adequate vocational assessment in a relatively short time, that is, on the basis primarily of what is usually a very brief interview (404). This presents an even greater problem when a handicapped youngster is concerned, in whose case so many factors must be taken into account, and so much varied information correlated. Most officers have fairly heavy case-loads, and unless the load is reduced for an officer specializing in the counselling of handicapped youngsters, the more demanding cases of handicapped young people must somehow be fitted in with the requirements of guidance for normal youngsters.

The complexity of the assessment of a handicapped youngster is described by one writer thus:

In assessing the potentialities of handicapped youth, one must consider not only attainments, aptitudes, and ability, but also factors such as the use made of intelligence, the young person's social acceptability, his attitude and that of the family toward his disability. Too much or too little parental care can be equally harmful. Employers have commented on the cheerful smile of a deaf typist, the courage of a paraplegic youth going to work in his chair, and "the not very bright lad" who is a trier (47).

Personal assets such as punctuality, good manners, and neat appearance assume even greater importance when assessing the potentialities of a handicapped person than when considering employment prospects for non-handicapped youth (47, 49).

The youth employment officer may also face the difficulty that many handicapped youngsters suffer the additional handicap of inadequate education as a preparation for job opportunities. This may occur when periods of illness or hospitalization have interrupted their education considerably, or when limited opportunities for special-school placement have resulted in neglected or curtailed education (2). In some cases the officer may find it necessary to refer the youngster for a course of medical or industrial rehabilitation or for vocational training before employment is possible. In general, vocational training courses sponsored by the Ministry of Education vary from two to four years in duration, and include further education, whereas those approved by the Ministry of Labour under provisions of the Disabled Persons (Employment) Act, 1944, are more concentrated. In either case, training for young people will usually be carried out at approved residential centers run by voluntary groups. The youth employment officer must be aware of current developments along these lines:

Among the newer ventures in these fields are a centre for vocational guidance established for blind adolescents, training courses for epileptics in clerical work and in silk screen printing at an epileptic colony, and a recently opened training centre for cerebral palsied persons, sponsored under the Disabled Persons (Employment) Act. In London a three-term course of further education and training in em-dicta typing has opened a new avenue to clerical employment for partially sighted leavers (47).

It is believed by some experts that the duties of the youth employment officer are complicated by a handicapped youngster's lack of preparation for employment that stems from too much emphasis in

the special schools on a broad education and general interests and skills, and too little emphasis on preparing the youngster for the type of employment and industrial conditions he may face on leaving school. Some proposals go beyond the kind of "vocational exposure" practiced at a number of schools, which includes talks to school leavers by employers, and visits to factories and other places of employment. It has been suggested, for example, that senior pupils in special schools be taught some of the skills they are likely to need in local industry by introducing into the schools some of the basic machines most commonly used in these industries. Another proposal is that some youngsters be permitted to leave school for a job before the statutory age, if they are physically and psychologically ready for such a move. However, the Working Party of the British Council for Rehabilitation of the Disabled maintains that the special school should continue to stress general rather than vocational education, as the extent to which the atmosphere of employment can be simulated within the school is extremely limited. It is more important for the school to conceive broadly its responsibility for vocational *guidance*, consulting with all persons and agencies concerned with the child in order to assure the consideration of the widest range of alternatives for him (10).

As indicated earlier, another problem faced by the youth employment officer in bringing to the attention of the handicapped youth such opportunities for further education and training is that there may be a discouragingly long waiting period, during which most of what the youngster accomplished in school may be lost. Some young people who do not qualify for further education, on the grounds that they would not benefit from it, may go to the limited number of voluntary and state-aided workshops, but the rest are left to fend for themselves—the slow developers, the mentally backward, and the maladjusted. The youth employment officer does what he can to persuade employers to hire these youngsters, but often this method of placement fails, and the youngster becomes discouraged and disillusioned. One writer maintains that even among those who are placed in jobs, most drift into unskilled jobs till the age of 21, when they are declared "redundant" (superfluous) and thereafter deteriorate rapidly in morale and physical condition. When some marry at a later date and have children, they often become a "problem family" (2).

The demands made upon the youth employment officer include the insights of an experienced social worker. He needs an understanding of family attitudes, since these can do much to impede or facilitate his work with handicapped youth. Some misguided parents deny the handicapped youngster the chance for training, either because they are unaware of the opportunities available or because they underestimate the abilities of the child (2). American studies have

confirmed English observations that there is a close relationship between the level of skills acquired by a handicapped child and his employability as a result of these skills in combination with the personality factors resulting from parental attitudes.

In many instances, therefore, the youth employment officer finds that employability cannot be determined solely on the basis of information about the nature and extent of the physical disability itself. For example, the Moed and Litwin study concerning the employability of the cerebral palsied found that emphasis on disability as such often obscures the importance of other factors such as family attitudes.

Although clients resembled one another so closely in physical condition as to be thought of as more alike than different, about half of them were considered potentially employable, the other half suitable for sheltered workshops only. The differences were felt to be psychological in nature and to have arisen from environmental influences and family attitudes rather than directly from the physical handicap itself (135).

The same writer emphasized the important influence of the family constellation.

Many of us who have worked with handicapped children and their families have noted the circularity of adjustments to children's traits and the determinant effect a family has on many of those traits . . . Fortunately or unfortunately the skills a child projects are partially determined by the values and attitudes the family exhibits. The circularity emerges as those very attitudes emerge as a reaction to perceived child traits (135).

The point was stressed that we need to know much more about this reciprocal effect through carefully conducted research.

Not only must the youth employment officer know the parents and home background, but he must also enlist the cooperation and understanding acceptance of potential employers. For instance, there is still considerable prejudice against the hiring of the educationally subnormal, in spite of favorable evidence from those who have employed them (93). The Central Youth Employment Executive has issued a memorandum of advice to local youth employment committees concerning the special needs of handicapped children, and though it is possible in larger areas to appoint officers with special interests and aptitudes to work with handicapped youth, this kind of appointment is seldom made, and as a result the youth employment officer usually deals with the handicapped only as part of his general duties, without special preparation for working with this

group. This lack of specialized preparation makes it all the more important for the officer to cooperate with other statutory or voluntary agencies in serving the young person, and to make use of whatever specialized information or experience is available.

Evidence concerning the problem of unemployment for handicapped youth comes from the Youth Employment Service of the London County Council (154). The number of unemployed handicapped young people on Aug. 31, 1962, was the highest on record; the 152 youth represented 8% of the total number on the special files at youth employment bureaus. Even the less severely handicapped who formerly were fairly successful in finding their own jobs have had to depend on the youth employment officers. Of course other factors rather than the condition of the labor market enter the picture, as in the appearance of a secondary disability in the case of a partially sighted girl trained in emi-dicta typing who developed seizures. Transportation problems continue to arise, as for a girl with brittle bones, trained in machine accounting, who must be placed within a short distance of her home. Openings may be limited by the special needs of the youth himself, such as a backward blind youth who is not equal to training but who is seeking work in light engineering. A particular problem is that of backward and immature young people who often have some physical weakness as well, and who without preparatory training are not fit for normal employment; yet existing training centers for the severely subnormal are not suitable for them. The rising number of multiply handicapped youngsters seeking employment places an added strain on the resources of the Youth Employment Service. But in spite of the decrease in employment opportunities, the Youth Employment Service reported continuing helpfulness and understanding on the part of the employers.

Although many suggestions have been made for the improvement of the Youth Employment Service, there is still general agreement that this is the most important service available to youngsters when they leave school, whether they are handicapped or normal. It provides the basis for a comfortable and effective transition from the academic world to the world of work.

Other services, to be discussed in the following section, are available through both voluntary and statutory agencies, especially through a broad rehabilitation program that includes registration as a handicapped person, and assessment in the government Rehabilitation Units.

REGISTRATION AND REHABILITATION SERVICES

The vocational assessment and placement services are part of the comprehensive rehabilitation program. This program comprises free

medical treatment for all, including medical rehabilitation, under the National Health Service; a disablement resettlement service to place employable disabled persons in suitable work; welfare and social work services for the severely disabled; and financial assistance where necessary (315). The specific services classified as rehabilitation and resettlement of adults registered as disabled of course include the *habilitation* and *initial employment* of handicapped school leavers who register.

Certain rehabilitation services are available to those who register as disabled persons under the Disabled Persons (Employment) Act, 1944. This Act defines a disabled person as "a person who, on account of injury, disease or congenital deformity, is substantially handicapped in obtaining or keeping employment or in undertaking work on his own account of a kind which, apart from that injury, disease or deformity, would be suited to his age, experience and qualifications." To register, a person must be likely to be disabled for at least 12 months and must be capable of remunerative employment, either in open or sheltered employment, when rehabilitated. The registry is divided into two sections, for (1) those who with or without special training can find normal employment, and (2) those who need special sheltered workshops. Persons who can never become self-supporting but who need continuous care and attention come under various welfare provisions.

Registration is voluntary for eligible persons, and is in force for a specified length of time, after which re-registration is possible.

Application for registration is made through a special officer called the Disablement Resettlement Officer, commonly referred to as a DRO. Since 1941 the Ministry of Labour has employed these special officers to give individual guidance, primarily to persons registered as disabled. One such officer is found in each of the more than 900 local employment exchanges in the country. He keeps the register of disabled persons, and is also responsible for placement and follow-up. The DRO does help some unregistered handicapped persons, but in general very few. Yearly the DRO's place over 70,000 persons in industry.

Before appointment the DRO has usually had considerable experience in the employment exchanges, placing in jobs either able-bodied persons or disabled persons, the latter under the supervision of a DRO. As a result he usually has a broad knowledge of industry in general and of the particular types of work available in his local area, including the specific operations and work effort they require. There has been some criticism that these DRO's lack flexibility and imagination in determining which handicapped young people are likely to qualify for employment under normal working conditions, but the Ministry of Labour points out that the real need is for more further education provided by local education authorities for handi-

capped youth so that they can more frequently qualify for certain training programs with prerequisites at present beyond the preparation obtained by the handicapped (10).

DRO's are often recruited from the ranks of social workers (93). Experience in social work is an important basis for building up close cooperation between the DRO and mental hospitals. In a few hospitals the DRO is in full-time attendance, at others he pays regular visits once or twice a week, and at still others he calls on request to interview patients (244).

The emphasis on the need of a broad background of experience and information for the DRO suggests a shift to a new concept of rehabilitation, from an out-of-context pathology-centered kind of treatment to a problem-centered program of assistance.

The business of rehabilitation is not uniquely associated with any one profession or type of institution. Nor is the "real" rehabilitation client a particular person or cluster of people. Rather, it is a series of interwoven social networks that constitute essential features of the life environment of the disabled . . . Effecting rehabilitation . . . may call upon a wide array of procedures for modifying social organizations and climates, including person-changing clinical techniques (313).

In the early 1950's about 900,000 persons were registered as disabled, but now the figure is about 650,000. The decrease is due to several factors, including the retirement of many disabled ex-service-men from World War I, and the tendency for others from World War II to allow their registrations to lapse after they have found satisfactory employment, and no longer regard themselves as disabled (134). The number of persons registering for the first time has stabilized at about 80,000 a year.

Registration does not of course guarantee employment; it simply provides help in assessing personal capacities, obtaining suitable training, and finding work. An inquiry by the Ministry of Labour's Joint Advisory Committee, covering over 175,000 men and women employed in August 1962, indicated that almost one-quarter of the unemployed men and one-tenth of the unemployed women were registered disabled persons. The Committee estimated that there was a hard core of about 100,000 persons unable to profit from rehabilitation or training even where there is a high demand for labor; this hard core consists mainly of unskilled workers, elderly or disabled, or both (95). Although the rate of unemployment is about three times as high among the registered disabled as among the non-disabled, it can be assumed that the difference would have been far greater were it not for the provisions of the 1944 Act (134).

Although the youth employment officer usually brings to the atten-

tion of the handicapped school leaver the possibility of registering as disabled, many handicapped youth do not take advantage of this opportunity. Whereas between one and two per cent of all school leavers are reported by the youth employment officer as handicapped, less than a third of these cases register under the 1944 Act. There are several possible reasons for this. School leavers are regarded as handicapped by the youth employment officer if he believes that their disability constitutes a serious problem, but the legal definition is narrower and therefore might not include all those considered eligible for registration by the employment officer. Also, since registration is voluntary, many youth who qualify for registration may simply neglect to do so, or in some instances may feel stigmatized by this admission of disability. Whatever the reasons, there is a question as to whether the fullest use is being made of the facilities provided by the Act (286).

Changes in public attitudes may be necessary before fuller use of registration occurs. The evidence indicates that since there is far less public understanding and sympathy shown for the mentally handicapped than for the physically handicapped, placing the educationally subnormal school leaver on the DRO's register usually labels him adversely and hinders rather than helps. This results in part from the fact that the public tends to confuse mental illness and mental subnormality, associating with the latter the more dramatic and sensational characteristics of the former (97).

Vocational assessment and placement can be obtained by registered disabled persons in Industrial Rehabilitation Units (IRU's) maintained by the Ministry of Labour. The purpose of the 17 IRU's set up in the main industrial centers of the country—and of the four additional Units to be added soon (293)—is not the remedying of specific disabilities or the provision of actual vocational training. Their purpose is to prepare the disabled person for regular employment in the same atmosphere, under the same discipline, and in the later stages of the course, at the same tempo as will be met in the future job (134). In other words, the aim of the IRU's is to create a workshop atmosphere with something of the pressure of normal productive industry, but not geared to specialized processes.

The Units provide machine shops, bench fitting and light assembly work, or woodwork of a basic type, plus gardening and other outdoor work. A sense of reality is given by the fact that most of these forms of work produce goods that can be sold. Refresher courses in English, arithmetic, and commercial subjects are given to those who are likely to go on into clerical work (286). Courses are individually planned and may run from 2 to 12 weeks according to need. Each Unit is equipped along the lines of a modern factory, and in each there are seven workshops and office sections under the charge of selected craftsmen. A consultant psychiatrist visits the

Units regularly, and there is a nurse and a remedial gymnast, with full consultant assistance available through the hospital service.

All applications, whether or not initiated by a doctor, are made through the DRO at the local Employment Exchange, who is responsible for helping to find the employment recommended at the end of the course. All types of disability—medical, surgical, psychiatric—are admitted if there is a reasonable chance for open employment in the near future (134).

For various reasons, about 17% terminate their courses prematurely; of those completing their courses, between 65% and 75% are placed in employment or sent for training within three months. Each year courses are taken by about 10,000 handicapped persons, including persons who are eligible to enroll even though they are not registered, as well as persons recommended by the Disablement Resettlement Officer. In addition, over 3,000 annually acquire new skills under the Ministry of Labour's Vocational Training Scheme. Since the introduction of the 1944 Act, over 130,000 have passed through IRU's and Vocational Training Schemes (134).

Evidence indicates that the IRU assessment program is serving many young handicapped persons. In the second half of 1960, out of a total of 5,200 entrants, 377 were young people between 15 and 17 years of age, and 304 between 18 and 19 years of age; the total of 681 represented 13% of the entire group (10). But some rehabilitation experts are dissatisfied with the present situation, maintaining that preliminary medical rehabilitation should be combined with the industrial rehabilitation in the IRU for young people, and that the needs of young people are not best served in a Unit comprising people of all ages. Lack of special attention to the social needs of youth in the IRU means that they are unlikely to feel at home there, though Ministry of Labour officials contend that special provision would not be desirable since the purpose of the Unit is to prepare for work in a normal industrial atmosphere. Others have objected to the screening process which rejects more severely disabled young people such as the cerebral palsied who, while unable to manage open employment, could still be fitted for sheltered employment (10).

Separate assessment centers are therefore preferable for certain kinds of handicap, such as are now provided by some voluntary groups. Examples of these are Hethersett for the blind, and the residential assessment courses provided by the Employment Department of the Spastics Society. There is need for more programs of this kind which combine further education with vocational assessment. This is not to say that the IRU is unavailable to or inappropriate for all young persons with cerebral palsy; there are some whose capacities can be properly assessed only on the basis of actual working performance in a place like an IRU (47) where they learn

to mingle with others and to conform to a working routine, profiting from guidance that includes both psychological and practical working tests (45).

There is conflicting evidence as to whether IRU's are willing to accept persons with mental difficulties. The London County Council reported in 1961/62 (154) that the Units had shown increasing willingness to accept maladjusted or ESN school leavers. In that year the Council had placed 31 handicapped young people in IRU's, a third of them in the residential course at Egham; the total included two partially sighted, one delicate, two ESN, five epileptic, seven maladjusted, and fourteen physically handicapped. However, a psychiatrist complained at a conference that most IRU's are reluctant to accept former mental patients discharged from a hospital, as in one unit where "If ever they are sent a patient with a psychiatric diagnosis he comes back within 48 hours allegedly 'disturbed.' It is just not good enough; all the work of the mental hospital in bringing the patient up to the point of discharge is lost when the point of discharge comes—by the Ministry of Labour, by the attitudes of the employers" (244). Yet at this same conference a representative of the Ministry of Labour stated that men and women with some form of mental disability constitute an increasing proportion of the IRU intake; in 1958 there were over 2,000 such cases, which were a fifth of all admissions to the units. More difficult cases are now accepted, such as the psychotics who were once excluded; about 600 a year are admitted. About twice as many psychoneurotic entrants—about 1,200—are admitted. It has been found that 63% of the psychotic and 66% of the psycho-neurotic complete their training, percentages that differ little from the 67% figure for all forms of disability. Mental defectives form the smallest group of mentally handicapped persons in the IRU's—about 200 a year—and a high proportion fail to complete their course of training, but of those who do complete it, the number successfully placed is fairly high (244).

There is some evidence that government Industrial Rehabilitation Units are accepting not only larger numbers of ESN or educable mentally retarded youth, but also more of the mentally subnormal, or the trainable mentally retarded. About 250 mentally subnormal persons were admitted to IRU's in 1961, and many of them were young people (268).

A few units are not running at full capacity but others have long waiting lists. There is only one fully residential unit, another that has a hostel attached to it, and still another which makes use of a local authority hostel.

In addition to the IRU's under the Ministry of Labour, other privately established rehabilitation centers serve a wide variety of handicapped groups. The costs of the services are met by the local education authority in some cases, and by the Ministry of Labour in

others. These centers differ greatly in their philosophies, organizations, and methods (286).

Roffey Park Rehabilitation Centre takes "short-term" neurotics and psychoneurotics, mostly breakdowns in industry but some from the professions. Patients usually stay only 4 or 5 weeks, with 10 weeks as the maximum, and so this brief period of segregation can be defended. But the IRU's are mixed, and this is said to add to their value by helping members to tolerate other people's handicaps as well as their own. The neurotic presents one of the most difficult problems to those in charge of rehabilitation, training, or sheltered employment. While there is no fixed limit to the number accepted, in actual practice only as many are accepted as can be absorbed comfortably into a workshop or center. Roffey Park takes cases not severe enough to require long-term treatment but still unsuitable for the IRU; it fills the gap often existing between hospital stay and employment in everyday life.

Among other independent rehabilitation centers are the Rehabilitation Centre at Farnham Park, a unit established by the Department of Physical Medicine in the Royal Hampshire Country Hospital, the workshops of the Austin Motor Company and Vauxhall Motors, a workshop in the Odstock Hospital in Salisbury, and Homes of Recovery for the Newly Blinded at Torquay (286).

The word "rehabilitation" implies that the many different programs described all have the common aim of recovering as high a degree as possible of normal function, including social adjustment. But the emphasis varies from scheme to scheme. For example, in a hospital the program may be patient-centered, and in the IRU job-centered.

PROVISIONS RELATED TO SPECIFIC DISABILITIES

The Ministry of Education requires that all blind school leavers attend a further education course that also provides vocational guidance. Such a course is given both at Hethersett and in Birmingham.

The first special placement service for the blind was provided in 1941 at St. Dunstan's, established in 1915 for the training and care of the war blinded. A similar placement service for civilian blind was begun in 1942 by the Royal National Institute for the Blind. This service was used by local authorities, though some authorities appointed their own part-time placement officers for the blind (206). The Ministry of Labour finally established in 1963 a special United Kingdom placement service for the blind to replace those formerly run by voluntary organizations and local authorities. This new service for the civilian blind has 30 specialized Resettlement Officers working in central locations. St. Dunstan's continues to serve the blind veterans.

School leavers from Condoover Hall school for the blind are categorized as capable of earning all or part of their own living in open industry or in workshops for the blind, working in an occupation center, helping at home, or at least occupying themselves part of the time. The more severely handicapped who need complete care and attention are sometimes placed in workshops for the blind when there is space for them, as in Birmingham (364).

The multiply handicapped blind need individual assessment and guidance. The capacities of these persons depend on the number and seriousness of additional handicaps, as well as the order in which they have occurred and the age at which they have been acquired. The combination of deafness and blindness is perhaps the greatest of handicaps, especially if the loss of both senses occurred in later life and the person concerned was intelligent. These circumstances may leave writing as the only occupation open to him. The deaf-blind are now less likely to be found in institutions for the mentally subnormal than before World War II, when their problems were less well understood (364).

The deaf-blind are classified as those with a "deaf mentality," that is, those born deaf or who became deaf in infancy, and those with a "hearing mentality," that is, those who became deaf later in life. Grouping on the basis of poor, fair, or good intelligence is important to assure contacts between deaf-blind persons of similar intelligence. Homes for the Deaf and Homes for the Aged are rarely satisfactory for them. Those with speech and some useful degree of hearing (with or without hearing aids) fare best in Homes for the Deaf-Blind, whereas those with poor intelligence are placed in similar homes designed for them specifically (323).

Deaf-blind young people have obvious communication difficulties which rule out their participation in courses such as those organized for the blind. Decisions as to the kind of training must take into consideration the conditions of the local labor market, and the recommendations of the local welfare officer. The following are examples of such cases:

Pat, a girl of 16. Considerable practical ability, a fair degree of useful sight, profoundly deaf and intelligence below normal. She can communicate only with simple gestures. Social behaviour: conforms reasonably well. The Staff at the school feel that Pat has some employment prospects and would not like to think that she did nothing.

John aged 16. Has good manual ability and a fair degree of useful sight. He is severely deaf, is of normal intelligence and can communicate by means of the deaf-blind manual. He could easily learn to be reasonably fluent with capital letters in print. John is somewhat immature, but

has a pleasant personality and the staff feel that he should definitely be employable.

David age 14. Fair practical ability. Profoundly deaf and with very small degree of sight. He is of normal intelligence and can communicate fluently through the deaf-blind manual. Social behaviour: quite good, though he is rather demanding of attention. There is a possibility of lack of home for David in the future (150).

These cases indicate the variety of factors that must be taken into account in placement.

The Register for the Partially Sighted developed from the National Assistance Act of 1948. The Ministry of Health has registration data for this group since 1952, and analyses of causes of partial sight since 1957. The certificates of registration for the partially sighted request information as to whether the person is likely to become blind within four years. This information is used by welfare authorities to plan for them early training as blind persons, and the provision of blind services if necessary (354).

A Sheffield study cited this case of a partially sighted girl:

She was very anxious to discuss the possibilities of training as a florist on leaving school, but was not able to obtain any serious consideration of her plan until the term before she left school. She was an intelligent girl aware of the limitations imposed upon her by her disability and anxious to choose a career within her capabilities. It seemed unrealistic that she could not be helped to plan for the career of her choice (96).

Conclusions from the study also stressed the necessity for examining carefully the welfare and employment arrangements for the partially sighted school leaver, and asserted that special vocational training facilities at present available only to the blind should be extended to include certain partially sighted persons.

This study illustrates the widespread concern about the adequacy of present placement procedures for the partially sighted. Ophthalmologists are not likely to be familiar with industrial processes. Industrial medical officers are in the best position to prepare up-to-date lists of suitable occupations. A classification into five groups of the partially sighted has proved helpful: (1) those with statutory defects, such as congenital abnormalities; (2) those with potential deterioration such as myopia; (3) those with progressive disorders such as retinitis pigmentosa; (4) other ocular disorders such as optic atrophy and diabetes; and (5) exceptional cases such as Eales' disease, a tuberculous infection (354).

Two considerations in discussing the vocational placement of the

partially sighted are the type of work and the misgivings the counsellor himself may feel about recommending certain kinds of work. Jobs should not be selected purely on the basis of the fact that they are unsuitable for persons who do not have full vision. Most jobs can be handled by persons without complete vision, and others can be performed after some retraining.

In other words we must open the doors wide instead of admitting the partially sighted through a mere chink (354).

It must be made worthwhile for them to register.

The degree of hearing loss is only one of a number of factors taken into account in decisions about the placement of children with impaired hearing (175).

The deaf youngster must receive a broad basic education before his vocational potential is assessed.

With the increasing complexity of modern industrial processes, the emphasis in schooling for the deaf has shifted from the traditional trade training in craft aptitudes and skills towards a more general education as a foundation for specialised training during employment. A good deal of specialised instruction in practical training is still given, especially in the residential schools for the deaf, both to boys and to girls, but the aim is to turn out young people with a broad general education supplemented by some acquaintance with special training (49).

Parents of epileptic children need more counselling than they are now being given, in order to understand the various implications of the child's condition, especially where there are emotional and educational difficulties as well. In the case of adolescent children with epilepsy, there should be early discussion, long before they leave school, of the anxieties which both parents and children have about the future implications of this condition (96).

Epileptic children are reassessed at school-leaving age as to the severity of the disability and the employability of the youngster. The school medical officer, who has this responsibility, may be assisted by the diagnostic department of a hospital. He cooperates closely with the youth employment officer as well as officers of the local authority health and welfare departments.

Employment opportunities of the epileptic are related to the person's intelligence, personality, attainment, aptitudes, and record of past employment, as well as the nature, frequency, and timing of his seizures. Many have attacks only at night or about the time they get up in the morning. Others have a monthly or even longer rhythm. A warning long enough in advance to enable the person to assume a safe position is a helpful factor. Work for those with occasional seizures must rule out types with moving vehicles or live machinery,

or kinds involving climbing ladders. There is some advantage in employing epileptics in pairs or small groups so that they can help each other (42).

Vocational training was a distinctive feature of early establishments such as the first school for the physically defective, opened in 1899 by Mrs. Humphry Ward; the Shropshire Surgical Home (later to become the Robert Jones and Agnes Hunt Orthopaedic Hospital) opened in 1900 by Agnes Hunt, herself a cripple from the age of ten; the Heritage Craft School at Chailey; St. Vincent's Home for Crippled Boys at Pinner; and the Lord Mayor Treloar's Hospital and College at Alton. Advances in orthopedic surgery made such training more feasible, although it was not till 1934 that the first training college for the adult disabled was founded. The increased manpower needs during World War II led to the reassessment of the potentialities of the physically handicapped, and this in turn led in 1944 to the Disabled Persons (Employment) Act. Such groups as cardiac cases, bronchitis, and the neurotic now come under the Act.

Physically handicapped youth need help in finding realistic goals. For example, one boy with a marked facial grimace wanted to be a TV announcer; another boy in a wheelchair wanted to be a professional football player. At times unrealistic aims like these must be discouraged while guarding against the danger of expecting too little (47).

One example of assessment and rehabilitation services are those provided at St. George's House, Harrogate, for between 50 and 60 senior girls and boys, including some young adults, divided into three groups of those suffering from cerebral palsy, among other handicaps: (1) those severely handicapped but of high intelligence; (2) those with a slight handicap but of low intelligence; and (3) those with a moderate handicap and low intelligence. Training is adapted to individual capacity and need, especially the different needs of the three groups. Productive work supplies neighborhood demand, such as the repair of antique furniture. Girls engage in mending, dress-making, embroidery, and the making of baby clothes, soft toys, and baskets. A few go into regular employment, and others return home less dependent on others for help (286).

Welburn Hall Special School for the physically handicapped conducts a one-day assessment program as a part of its program to achieve correct initial placement of school leavers. Where necessary, children are referred to an Industrial Rehabilitation Unit for more detailed examination. Inquiries concerning former pupils indicate that the great majority are established in congenial employment and earning a satisfactory wage.

One special group of physically handicapped school leavers who are felt to deserve more attention than they have had so far are those with congenital or acquired conditions who have been adequately

treated and who appear to have little or no disability when assessed at this stage. They might compete satisfactorily in the open labor market but may develop trouble in later life. This sometimes happens in children with congenital dislocation of the hip and Perthes disease who may develop arthritic changes. School leavers who have compensated well for polio may because of lack of muscle tone become de-compensated in middle life. These youngsters need advisement not merely in terms of the immediate future but also in terms of 10, 20, or 30 years later.

It would be obvious folly for a child to take up training as a Physical Instructor if it were known that her hip was likely to respond unfavorably to prolonged activity over many years (114).

An inaccurate assessment after accident or illness is sometimes made by physicians who know the disability but not the conditions under which the patient works or wishes to work (114). It is charged that many doctors know too little about, and take little interest in, the working lives of their patients; they rarely see the inside of a factory, know little about the physical and mental demands made by the patient's job, and are even unaware of the medical and other facilities provided by the company (157).

This situation may also be complicated by the employer's unwillingness to accept any risk in the placement or re-placement of an employee, and who therefore assigns him to "light work." This makes it difficult for the employee to keep his self-respect when he feels that he is actually capable of performing more complex tasks. Another obstacle is the idea that the worker must be completely cured beforehand, when often the best exercise for an injured limb is the constant attempt to perform its customary activity (114).

Limitations to be considered in evaluating the potential of the cerebral palsied are the following: (1) mental disability (most athetoids show normal intelligence but more of the spastics show a less than normal intelligence); (2) eye defects; (3) hearing difficulties; (4) speech difficulties; (5) disorders of sensation; (6) disorders of respiration. Thus the finding of suitable work for CP's is more difficult than for many other forms of disability. Additional factors that must be taken into account when selecting suitable work are the extent to which the use of normal or above normal mental capacity is prevented by associated physical disabilities (1).

The assessment and guidance of the youngster with cerebral palsy is complicated by a high frequency of multiple handicaps. A study of 343 cerebral palsied children revealed that 14 were found unsuitable for education in school after a year's trial; 12% had epilepsy; 52% had speech defects; 2% had defective hearing; 20% had defective vision; and 22% had social problems, the commonest being lack of parental affection or general attention (183).

At the school-leaving age of 16 years as many as 40% to 50% of spastics may be too immature or too severely handicapped to enter any kind of training or work. Some not yet fit for work benefit from a course of further education and training such as the one run by the Spastics Society at Colwall Court, Bexhill, during which their suitability for open or sheltered employment is studied. This program is voluntary, and some parents object, believing that a job is waiting around the corner for their youngster. Alternatives are attendance at a day center of the local health or welfare authority or at one run by a voluntary group, attending on a part-time basis, with diversionary work. Some centers have working groups who learn to produce marketable articles or do sub-contract work such as assembling or finishing for industrial firms at regular wages. If the gains made at school are to be preserved, the youth without occupation needs the discipline of regular attendance at some such center to promote their social development and capacity for useful activities (46).

The Careers and Employment Department of the Spastics Society provides a comprehensive service including vocational guidance and assessment, training, placement in employment, casework, liaison with statutory and voluntary agencies, cooperation with and advice to employers, and the planning and development of services for cerebral palsied adults. The kinds of employment provided include open employment; sheltered employment in workshops run by the Spastics Society, Remploy, or other voluntary groups; employment in work centers or occupation centers run by local authorities or local groups of the Spastics Society; work in residential work centers run by the society or other voluntary organizations; homework in various crafts; and self-employment in small businesses such as commercial printing, chicken-keeping, and a retail shop. Referral for service may come from the cerebral palsied persons themselves or from parents, local groups of the Spastics Society, other charities, and any other interested parties such as a vicar or employer. If further information beyond that provided by available records and the initial interview with a staff member is considered desirable, the person can be recommended for an IRU assessment, or for an assessment course run by the department.

This department tries to initiate some vocational guidance two years before the youngsters leave school through a careers advice officer and his assistant. Five residential two-week assessment courses a year are held in various parts of the country for difficult cases. These short vocational courses were organized as it became evident that simple interviewing techniques were insufficient for determining potential. In these courses groups of about 25 youngsters with cerebral palsy live side by side with members of the Employment Department Staff, who employ many ingenious tests especially devised for this work. In addition, two further-education courses have been or-

ganized for school leavers who lack the necessary maturity for entering employment or training immediately after leaving school, and a new further-education center was opened in 1963 (355).

Social workers provide a continuous link with parents of children with cerebral palsy. There is intensive casework for the critical transition periods from home to school and when leaving school. Parents are encouraged to spend a week at a time with their children at the centers and schools. Sometimes they bring siblings. In the summer of 1963 an assessment center was set up by the society at a holiday hotel at Clacton-on-Sea near a promenade, amusements, beach, and shops; opening July 10, it started with ambulatory cases, ten each week for a three-month period. Each youngster had a week's assessment program, with the mother present.

Assessment for employment of young people with muscular dystrophy is more important than formerly because so many more live to become adults. In some forms of muscular dystrophy there is progressive muscular deterioration, and many of the victims die at an early age; for youth with such a form of the disease there is little demand for vocational guidance and placement services. The Duchenne type of muscular dystrophy, usually inherited as a sex-linked recessive character, occurs principally in young boys, and begins between the ages of 2 and 3 years. Most of these patients die between the ages of 14 and 20 from pneumonia or sudden cardiac failure, while the few who survive longer are helplessly crippled. The limb-girdle type resulting from an autosomal recessive character occurs with equal frequency in the two sexes, with the commonest age of onset in the teens. It progresses more slowly but usually produces severe disability in middle life. Another form with an age of onset in the teens in both sexes is the facioscapulohumeral, determined by an autosomal dominant mechanism. It may produce arrested effects on only a few muscles, or continuous deterioration with long plateaus. Some of these persons remain active throughout their lives and have a normal life span. This group and the group with the limb-girdle type include adolescents who need vocational and employment services.

From the time the disease is first diagnosed, education and training are directed toward some sedentary occupation and hobbies such as drawing and painting, or other activities requiring only the use of the hands. Because of the hereditary nature of the various forms of the disease, genetic counselling is desirable.

It is recognized that self-reliance and a realistic acceptance of the limitations imposed by hemophilia must be taught the boy at an early age. His interests are directed toward a vocation requiring mental ability and manual dexterity rather than strength. The boy is encouraged to read, write, draw, sing, and play instruments. He may go to a regular school, to a special school for the physically handicapped, or

receive home instruction. All but the most severe cases are usually physically able to attend a grammar school. Intelligent boys are encouraged to get a university education looking forward to employment in the liberal professions, science, and the arts. Many of the less intelligent successfully pursue occupations such as watch and clock repair, clerical work, and photography.

Hemophilia is cyclical and varies considerably from week to week and year to year. Frequently there is no outward indication of the disability, and teachers and employers may not understand a patient's unwillingness during a bad phase to undertake tasks he would normally accept. This is a particularly difficult problem if the hemophiliac wishes to conceal the condition from his employer. The moderate hemophiliac, however, is at least as regular in attendance and as conscientious in performance of duties as any other employee (70).

Educationally subnormal youth are the largest single group who need guidance and assessment aid from the Youth Employment Service. For example, 787 of the 1,735 young persons on the handicapped files of the Youth Employment Service of the London County Council in 1961-62 were listed as ESN (154).

The mentally retarded youth fail to get or hold jobs because of: unrealistic wage demands; poor appearance; over-protective or unrealistic parental attitudes; inability to pass tests; fear of physical examination; inability to travel alone; lack of dexterity; slow performance; lack of concentration; inability to get along with others; lack of comprehension of what is expected; inflexibility; absenteeism; and lack of understanding by supervisor (158).

The Spring Wood School for ESN pupils aged 7 to 16 prepares boys for jobs in a three-phase program — industrial visits, classroom study, and work under factory-type conditions known as the "factory day." Visits are made to various work settings to acquaint the boys with the widest possible variety of working conditions. The boys plan their own routes to and from these places. They meet at the factory entrance, and are informed about the checking-in points, cloakrooms and lockers, cafeterias, restrooms, and the like. In the classroom they learn how to fill out various forms such as application forms and licenses, discuss "Situation Wanted" columns, and clarify the meaning of unfamiliar words such as "experienced," "youth," and "apply." The advantages and disadvantages of various kinds of work are discussed, as well as applying for jobs by calling, telephoning, and writing. Arithmetic is related to the calculation of wages, making out budgets, and understanding the nature of deductions from the pay check. The "factory day" is conducted in the woodwork room, with time clocks, brief rest periods rather than playtime, and the making of useful products. The teacher acts as a foreman, and attempts to create as much as possible a factory atmosphere (141).

In Bristol, the youth employment officer and the Special Schools After-Care Officer cooperate in the placement of ESN school leavers. A conference attended by school medical officers, psychologists, head teachers, mental health officers, after-care workers, and the youth employment officers is held to consider each youngster's future. This committee tries to recommend employment suitable to the child's capacity and temperament, in the light of his ability and his parent's wishes, and the recommendations of the psychologist and the head teacher. Children considered unsuitable for employment are referred to the local health authority for occupation and training in the adult training center. Similar help is given to the ESN pupil in Liverpool.

The emotional immaturity of many ESN school leavers may necessitate continuing supervision for several years after they leave the special school. Birmingham entrusts to the Special Services After-Care Sub-Committee of its Education Committee responsibility for the supervision both of children who are unsuitable for education in school and of those in need of supervision on leaving school. The Health Committee is represented on this Sub-Committee, and the Education Committee, to which it reports, acts in effect as the agent of the Health Committee in the discharge of its statutory duties (10).

At a 1962 conference of the National Association for Mental Health at Worcester College, Oxford, some of the problems faced by ESN youngsters on leaving school were discussed. Teachers gave a more hopeful picture of their employment adjustments than did social workers, who were more likely to have contact primarily with misfits. Most ESN school leavers make the transition to employment with fair success, and for this purpose they need chiefly three things: work, a place to live, and something to do when the workday is over. People tend to concentrate on only one of these needs, overlooking the others. Although most of these youngsters live at home, those with unsuitable homes or with no home need some kind of hostel accommodation. They all need the chance to make friends and eventually to find a spouse. In some instances a youngster has been passed along year after year from one unwilling teacher to another while attending a special class in a regular school. This special class sometimes comprises both very young children and also "hefty lumpish girls and tall weedy youths with drainpipe trousers, pointed shoes, and round shoulders." The child's chances of success after leaving school depend on the kind of support given him both by his family and by the community. Acceptance is more likely in a tightly knit community like a village or an older urban area than in a detached industrial one where even a good home and a good school might not enable a boy to succeed. The need for acceptance is one reason why such youngsters seek further education, for they go not so much to learn a subject or to take part in some form of activity as to feel wanted, to feel that they are part of the community (78).

A combination of vocational and social skills and information is taught the ESN youngster in order to make it possible for him to be happy on a job and to hold his job. These include good manners, a positive attitude toward health and personal appearance, a knowledge of means of getting employment, ability to follow directions, understanding how to travel in cities, and experience in general job training. Specific vocational information is provided by listing types of industry and types of employment available in the district, and continuing visits to industry correlated with work in arithmetic and English (27).

It is clear that many observations obtained from different types of tests are needed in order to assess adequately the potentials of the mentally subnormal, or trainable mentally retarded. The purpose for using tests such as those measuring personality or educational achievement is not merely to determine the presence or absence of a particular skill or trait, or to find out how much below normal a given kind of achievement is, but to determine how much effective use is made of the youngster's capacities.

The inadequacy of the IQ measurement alone as an index of practical or social intelligence in the retarded youngster is well illustrated by an example given by Gunzburg in "Social Rehabilitation of the Subnormal" (90):

Bernard and Richard are extremely good friends and their long-lasting friendship is rather unusual for subnormals. The two friends decided to buy a wireless set on a deferred credit system, and arranged that each should pay half of the weekly installments. It fell to Richard to pay in the sum of 12s. each Friday. Richard was in regular employment and the payment of 6s. was quite easy for him, but Bernard found it far more difficult to scrape together his share of 6s. from his pocket-money. Yet he managed and for some time carried his regular payments. In this he was greatly helped by the fact that Richard, realizing his friend's precarious financial position, made Bernard a present of 6s. every Monday. The comedy of Bernard paying Richard 6s. on Friday and receiving from Richard 6s. on Monday carried on for some time and during that whole period Bernard was absolutely convinced that he himself paid his fair share of the wireless. It never dawned on him that the two different sums of money were in reality one and that he had not made any contribution of his own.

It is interesting to note that Richard, who was fully aware of the implications of the arrangement, had an I.Q. of 59. Bernard, the simple soul who was unable to see through his friend's well-meaning machinations, had an I.Q. of 74. This is a good example to show how little the

quantity of the I.Q. reflects the quality of the thinking processes and how misleading the rash conclusion can be that the higher I.Q. automatically denotes a better ability to cope with life.

The need for attention to personal and social adjustments as integral factors in potentiality for employment, and as an intimate part of the training provided, is found in the treatment of more severely retarded or emotionally disturbed youngsters committed to a mental hospital. Immaturity may be just as important a determination as the mental subnormality itself:

It is worth speculating whether the stabilization effected by four or five years' residence in hospital during adolescence is due so much to the regimen to which these patients were subject, or whether it was merely the result of increased maturity which is always invariably late in making its appearance in subnormals. Although most patients of this level may be physically and intellectually capable of working, their present inability or previous failure to do so satisfactorily cannot be put right by a mere insistence on work. The patients' essential limitations and adverse personality factors must be taken into account and dealt with before success can be hoped for. In these cases the importance of suitable employment lies in the means which this provides to deal with the personality problems which the patient presents on a concrete level, and using a setting which he can understand. In this way such work can provide the basis of a therapeutic relationship with severely practical aims, because in this context it provides a framework in which the patient will exhibit his normal attitudes not only towards work but towards authority, other people, and life in general, and it is here that help and re-adjustment are required (244).

The work program provided in the hospital must be realistic, must approximate normal employment, and must demand concentration and persistence of effort. The practical problems faced in organizing and maintaining such a program of work were discussed in detail at a 1959 conference on the place of work in the treatment of mental disorder.

CONCLUSIONS

An accurate and meaningful classification or assessment of the handicapped school leaver is of first importance in helping him to find a place in the adult community, especially in the world of work. A special committee on the handicapped school leaver appointed by the British Council for Rehabilitation of the Disabled has given some suggestions for arriving at a more helpful classification system. Al-

though a clinical classification in terms of etiology is important for medical treatment, a functional classification is necessary for purposes of rehabilitation in the sense of settlement in the home and community (97). This kind of classification should indicate the nature and severity of the handicap as well as the name of the disease. In addition, a concept such as "intellectual age" would be more useful than expressions such as "educationally sub-normal" or "dull and backward" as presently used. In terms of prospective employment, two other psychological dimensions might be added: (1) educational standard, such as reading and arithmetical age; and (2) social adjustment. In other words, some kind of sound operational classification is needed.

The more severely handicapped adolescent is particularly in need of a system of careful assessment, since it is all too easy to assume that he is incapable of employment. It has been asserted that if the community assured him of further education, occasional work experience on selected jobs, and medical treatment, both the youth employment officer and the Disablement Resettlement Doctor would have an easier time placing him. The logical solution is to provide him with sheltered undertakings with hostel accommodations, where education can be continued and where he can be trained in two or three different kinds of work at first to find out what he can do best. If the workshop atmosphere approximates that of normal industry, one can obtain a good idea as to whether he could hold a regular job satisfactorily (95).

The classification of the handicapped youngster resulting from his initial ascertainment for the purposes of education is not at present an adequate basis for vocational assessment. The Working Party of the British Council for Rehabilitation would bridge the gap between educational and vocational assessment by making ascertainments "a continuous process embracing the views of all concerned with the well being of the handicapped child," these views to be as enlightened and informed as possible (97).

Chapter 4.

Vocational Training

In general, vocational training can be obtained in government training centers; in voluntary-society training colleges, centers, and workshops; in training programs maintained by some employers; and in correspondence courses provided by some public or private agencies.

GOVERNMENT CENTERS

The Ministry of Labour sponsors 13 Government Training Centres. These were established as Government Instructional Factories by the Ministry of Pensions in 1917, and then two years later became the responsibility of the Ministry of Labor under their present name (218). The training is free, and the trainee gets a weekly allowance from the Ministry to maintain himself and his dependents, the amount varying with family circumstances and whether the training is given locally or away from home. An allowance is also given for daily traveling expenses. If the individual leaves home for training, he is either accommodated at the center free of charge, or the Ministry helps him to find lodging and pays an allowance for his quarters (219).

These government centers differ from voluntary ones in several ways, aside from the administrative distinctions:

1. Training is provided in the GTC for able-bodied as well as handicapped persons. The GTC trains primarily those who are social problems — ex-servicemen, the hard-to-employ non-handicapped (those who “have missed their way of life”), and the handicapped (286). About 60% of those trained are disabled (10).
2. The handicapped persons in these centers are less severely handicapped than in the voluntary centers.
3. Training is given for employment involving a higher level, and greater variety, of skills than in voluntary centers, and include more strenuous occupations (286). The total does include some of the skills taught in centers for the more severely handi-

- capped, but not courses such as fine needlework that may require several years for achieving competence.
4. Training is directed specifically toward open employment, which occurs only in a minority of cases in voluntary centers. As a result, the general atmosphere of the GTC approaches more closely that of a normal factory than does the other type of center.
 5. The government training center can provide further education when needed, as distinct from training. The center enrolls handicapped youngsters for further education when it is needed to enable them to profit from the training program of the center.

The courses frequently chosen by trainees include hairdressing, typewriter repairing, watch and clock repairing, radio and television repairing. Also there is training as fitters, instrument mechanics, motor repairers, plant maintenance mechanics, engineering draughtsmen, carpenters and joiners and cabinet makers. Some 17 trades are taught at Aintree, 23 at Letchworth, and 15 at Leeds. The courses vary from 6 to 12 months in length, with a planned timetable for each course, though each person's progress is charted individually.

The scope and variety of training courses reflect existing conditions, and courses are changed if they become unpopular. Thus certain courses in leatherwork and the making of surgical appliances have been replaced by commercial courses (10).

The handicapped youth is brought to the attention of the youth employment officer, who then consults the Disablement Resettlement Officer about placing him in a government training center. It is often a social worker in either the health or welfare services who helps the handicapped youth in this transitional period, and brings to his attention services of which he might otherwise be unaware. By keeping in touch with him before he leaves the regular or special school, and working in close cooperation with the youth employment officer, the social worker serves an important role in the period between leaving school and entering training or a job (353).

There is a plan to add 18 more centers over a period of time to meet the need for additional training places, even though some of the present centers at times have places that are not utilized. It is occasionally difficult to take advantage of the services of a center because in general provision for the housing of trainees is inadequate. Only about half the present centers provide hostels, and it is often particularly difficult for the handicapped to find suitable accommodations.* Also a very large hostel, like the one for 350 men at Letch-

* Interview with Mr. S. Goldblatt of the Ministry of Labour, July 1963.

worth, may be unpopular with persons who have spent a long time in the group life of hospitals and consequently prefer the greater privacy of separate lodgings. Smaller hostel units would facilitate integration into the community.

Meeting trainees in an I.R.U. (Industrial Rehabilitation Unit) or G.T.C. which does not provide residence, one wonders what contacts they have with the local community. Birds of passage though they are, imaginative and understanding leadership might find a way of offering them hospitality and social life in forms they could accept (286).

In addition to the courses in government training centers, the Ministry of Labour sometimes arranges short courses of about three-months' training for semi-skilled employment, these courses being offered at employers' establishments if they provide the only good prospects of a regular job. At first a training fee is paid to the employer and a training allowance is given to the trainee, but these are gradually tapered off as the trainee becomes capable of earning regular wages (10).

Although the function of the Industrial Rehabilitation Units is to assess the individual's potential and to place him in a job, they may recommend vocational training before seeking employment, if the assessment indicates this is desirable.

VOLUNTARY CENTERS

Voluntary training centers play an important role in extending and augmenting the services provided by the government centers. They operate generally under two programs of assistance from the Ministry of Labour:

1. Grants to students taking courses at voluntary centers under the Disabled Persons (Employment) Act, 1958.
2. Grants directly to voluntary societies providing vocational training programs for severely disabled persons.

The first kind of provision is for persons who can participate with the normal in training and education. The registered disabled with suitable ability can obtain grants enabling them to take courses of training or study sponsored by voluntary groups, including university courses for certain fields. The Disabled Persons (Employment) Act, 1958, reduced the minimum age for vocational training and industrial rehabilitation from 16 to 15 in order to allow for the inclusion of handicapped youth attending regular schools, where the school-leaving age is 15. Assistance covers tuition, examination fees, and a sum toward cost of books, along with a maintenance grant. The youth make their own arrangements for training to meet the requirements of the professions concerned, and follow the normal courses except

for the specialized training provided for the blind in the Royal National Institute's School of Physiotherapy (286).

Mr. S. Goldblatt of the Ministry of Labour kindly provided the writers with the following unpublished data concerning the applications made by the sighted civilian disabled and by the blind for government grants for professional training in the period from April 1, 1949 — when for the first time data for disabled ex-servicemen were separated from data for the civilian population — till March 31, 1963 (220). The term "professional" appears to be used in a somewhat broader sense than that employed in most discussions in this country.

Disabled Persons (Employment) Acts 1944 and 1958

Professional Training

Analysis by professions of applications made by Sighted persons

from 1st April, 1949 to 31st March, 1963

	Applications	Awards	Rejects	With- drawn	Still under consideration
Accountancy	73	26	35	10	2
Advertising (incl. Commercial Art)	138†	30	90	18	—
Agriculture and Horticulture ...	41	15	16	8	2
Architecture	36	18	16	2	—
Arts: Music (incl. Teaching) ...	52	21	30	—	1
Others	33	7	24	2	—
Auctioneer and Estate Agents ...	42	21	14	7	—
Civil Aviation	2	—	2	—	—
Civil Service	7	2	5	—	—
Commerce: Secretarial	57	31	19	7	—
Others	8	5	2	1	—
Dentistry	12	6	4	2	—
Engineering	117	37	61	18	1
Forestry	4	—	4	—	—
Hotel Management	4	—	2	2	—
Industry	68	23	30	15	—
Laundry Management	1	—	—	1	—
Legal: Barristers	27	7	18	2	—
Solicitors	46	24	18	4	—
Librarianship	22	10	8	4	—
Local Government Service	14	4	9	1	—
Medical Auxiliary:					
Chiropody	91	33	49	9	—
Occupational Therapy	86	45	27	13	1
Osteopathy	1	—	—	—	1
Physiotherapy	35	9	20	5	1
Radiography	31	12	15	4	—
Speech Therapy	7	4	1	2	—
Medicine	58	26	25	6	1
Merchant Navy	11	5	4	1	1
Ministry: All denominations	41	16	23	1	1
Nursing	6	4	1	1	—
Optics	17	6	9	2	—
Orthoptics	2	2	—	—	—
Pharmacy	13	8	4	1	—
Social Services	86	37	41	7	1
Surveying	43	14	21	8	—
Teaching	195	81	90	24	—
University Degrees	117	38	67	12	—
Veterinary Surgery	7	2	4	1	—
Others	12	3	4	5	—
TOTAL	1,663	632	812	206	13

† Includes one transferred to another Training Scheme.

Disabled Persons (Employment) Acts 1944 and 1958

Professional Training

Analysis by professions of applications made by Blind persons

from 1st April, 1949 to 31st March, 1963

	Applications	Awards	Rejects	With- drawn	Still under consideration
Arts: Music (including Teaching)	10	6	2	2	—
Engineering	1	—	1	—	—
Industrial	1	—	1	—	—
Legal: Barristers	2	—	2	—	—
Solicitors	35	24	2	1	8
Medical Auxiliary: Physiotherapy	220	156	39	15	10
Medicine	2	1	—	—	1
Ministry: All denominations	1	—	—	1	—
Social Services	5	3	2	—	—
Teaching	5	4	—	1	—
University Degrees	2	—	1	1	—
TOTAL	284	194	50	21	19

Inspection of the Ministry of Labour data on professional training awards to sighted persons indicates that the occupations with the highest number of applications ranged as follows in their order of frequency: teaching, advertising, engineering, university degrees, chiropody, occupational therapy, social services, accountancy, industry, medicine, secretarial work, music, legal solicitors, surveying, auctioneer and estate agents, agriculture and horticulture, architecture, and physiotherapy.

Grants for training were given to only 39% of the sighted applicants as a whole. The highest percentage for individual occupations was only a little over half — 54% for secretarial training — with only four others showing a percentage of 50 or over: occupational therapy (52%), legal solicitors (52%), auctioneer and estate agents (50%), and architecture (50%).

A similar inspection of data concerning the blind indicates a much narrower range of occupations, with noticeable concentration in the one category of physiotherapy; in contrast with 78% of the total applications falling in this field, the highest percentage in any one field for the sighted disabled was 12% in teaching. The two other areas of concentration for applications by the blind are legal solicitors (12%) and music (4%). However, this disparity in comparison with the sighted distribution would probably be less evident if the data for the sighted disabled were broken down into more specific categories of handicap. One can only speculate as to whether the data for the blind indicate more realistic vocational goals and assessment for these goals, or an extrinsic emphasis on the suitability and availability of certain kinds of employment.

Whatever the reason, higher percentages of awards were made for the three major occupational categories of blind applications than for the sighted: 78% of the applications for physiotherapy training were accepted for awards, 67% for legal solicitors, and 60% for music.

The second type of provision subsidized by the Ministry of Labour is designed for those persons who need very special arrangements for training and those who can be prepared for sheltered employment but not for open employment. The Ministry of Labour's Scheme of Grants to Undertakings Employing Severely Disabled Persons specifies the conditions under which voluntary organizations can receive deficiency grants and capital advances, and their trainees maintenance allowances. The same arrangements apply to workshops for which local authorities are responsible. The scheme is intended to assist "registered disabled men and women who, on account of the nature or severity of their disablement, are unlikely to obtain employment in ordinary industry but would be employable under special conditions." Thus the intention seems to be to enable these groups to train those who could not be employed even in a sheltered workshop without training, and then to employ them when trained. A small number do actually pass into open industry, but this number varies from one center to another. The trainees not only acquire certain knowledge and technical skill but must learn to compensate for the loss of a limb or function by using another limb or muscle group. It is found that processes that demand little specialized skill from an able-bodied person often call for great effort and perseverance from a handicapped person (286).

At a voluntary center, the society pays the capital expenditures and the Ministry of Labour pays the running expenses by means of a per capita fee per person per week. Government inspectors make annual visits to compare the progress of individual trainees with a standard chart. The centers maintain close associations not only with the Ministry but also with industry and trade unions. This kind of cooperation is important in assuring that once a young person has been trained, there will be job opportunities for him. As one writer commented in discussing the chronically ill adolescent, when a person has been trained and has done well and then cannot be placed, this last stage of frustration and despair is often worse than the initial one (226).

Whether the voluntary training center is recognized by the Ministry of Labour, the Department of Education and Science, or both depends on the nature and purpose of the training provided. Courses provided or subsidized by the Ministry of Labour are fairly short (except for a few skills like needlework) since they were designed originally for the retraining of persons who had become disabled after beginning employment. Trainees were not accepted in these

courses unless they were likely to become wage-earners. The training courses recognized by the Department of Education and Science are normally of three years' duration and combine an educational program with the vocational training. This longer period allows young people to be tried out in various trades if necessary until the one best suited for them is determined. It also means that trainees can be accepted even though their ultimate employability may be in doubt. For example, the Lord Mayor Treloar secondary school for the physically handicapped is only recognized by the Department of Education and Science, but it is linked with the Queen Elizabeth and St. Loyes centers as far as young people up to the age of 18 are concerned, these centers being recognized by the Ministry of Labour for all ages.

Four principal voluntary training centers, with a total of 555 places, are recognized by the Ministry and used for placement of severely handicapped men and women:

Queen Elizabeth Training College for the Disabled,
Leatherhead

St. Loyes College for the Training of the Disabled, Exeter
Portland Training College for the Disabled near Mansfield,
Nottinghamshire

Finchale Abbey Training Center for the Disabled, Durham

All are residential centers specially equipped to meet the needs of those with extensive disability.

Queen Elizabeth's College specializes in hand-painted titles and fine needlework, whereas St. Loyes College gives instruction in the making of light clothing, leatherwork, and watch and clock repair. These two institutions, which were among the pioneers in training the severely disabled, are recognized both by the Ministry of Labour and by the Department of Education and Science. Handicaps are regarded as specific, disabling only for certain activities and occupations. St. Elizabeth's provides 196 places, and St. Loyes 155, with 16 and 18 training courses respectively. As compared with Government Training Centres, most of the courses prepare for forms of employment involving less physical strain, that is, less standing and carrying. But some engineering is included at Queen Elizabeth's, and at both colleges, electrical servicing. A large number of the residents at these colleges are chairbound. Prerequisites for acceptance are intelligence, the will to succeed, and sufficient mobility to get to work (via a car with specially adapted controls or a powered chair or tricycle) and to adjust to normal hours and conditions (286). The 1962 Annual Report for Queen Elizabeth's gives an analysis of the disabilities of trainees placed in employment between 1934 and 1962, and states that in that period over 6,000 severely disabled men and women, coming from all parts of the British Isles and even from

abroad, had been trained by the College for employment in industry (311).

St. Loyes has a special section for juniors accepted through local education authorities from the age of 15 and, in exceptional cases, at the age of 14. Some may already have attended special schools; others may have had little or no schooling; and some may have spent years in a hospital. At the training college their education is continued and special attention is given to developing character and a sense of responsibility. In addition, their experience in the vocational training courses accustoms them gradually to an industrial environment. The aim of the college is to enable them to be transferred to a vocational course under the Ministry of Labour, though the transfer is not considered before the age of 16 and in many cases even later (339).

The Portland Training College was planned specifically to provide residential training for miners and other disabled men from the Midlands, but it does accept people from other areas. It has 94 places, and offers courses that include instrument making, commercial subjects, and gardening.

The Finchale Abbey Training Center of Durham Country has 110 residential places with 8 training courses that include gardening and other work on an estate. There is no engineering instruction here. The most common form of disability found among the trainees is pulmonary tuberculosis.

The length of training courses varies from the few months needed to learn some simple types of machine-operating to the two or three years or even longer which may be needed to acquire skill in basket-making or fine needlework. Most courses last at least six months. A particular course can be extended in an individual case where it seems necessary to allow more time, and sometimes changes in courses can be suggested to meet individual needs (286). The Ministry of Labour controls the selection of the youngsters it refers for training, but this is done in consultation with the training center concerned. It is estimated that between 500 and 600 additional places a year are needed for persons the Ministry cannot yet accommodate.*

In addition to these four centers, there are various voluntary sheltered workshops which include programs of special training that sometimes lead to open employment. The Anne Glassey Workshop at Wallasey is a rehabilitation center for post-tuberculous men and women. Few of those who have entered open employment from this center have continued the machine knitting taught there, but this is a real workshop producing for a market, generally to order, and the training can lead to employment in the skill learned. The Sir Robert Jones Memorial Workshop at Liverpool teaches, among other trades, fine bookbinding to fill orders from local firms. Of the 23% who go

* Interview with Mr. S. Goldblatt.

into open employment, not all use the trades taught in the workshop. The School of Stitchery and Lace at Great Bookham, with 25 trainees and a sheltered workshop for 9, also sends some persons into normal employment, but this is not true at the Lord Roberts Workshop at Liverpool which trains and itself employs 87 severely disabled men (286).

A considerable amount of vocational training for various handicapped groups is thus provided by voluntary organizations with the assistance of government agencies.

TRAINING IN INDUSTRY

Aside from the firm-centered training sponsored by the Ministry of Labour, various industries may provide training programs of their own for employees. Both normal and handicapped youth can apply for apprenticeship training, which is much more common in England than in the United States.

In the discussion of special education, it was pointed out that preparation in technical colleges is considered further education, whereas that received in industry or in specifically designated training centers is called training since it is less academic and more specifically vocational in content. However, some dovetailing of further education and training may occur, and the line between the two is growing less distinct. For example, a memorandum from the Ministry of Education to local education authorities in September 1963 indicated approval of a recommendation from the Federation of British Industries that employers provide college-based sandwich-course students with opportunities for practical training at trainees' normal pay rates.

Training for a craft through apprenticeship usually lasts 4 or 5 years, and is completed by the age of 21. Although most of the training is done on the job under the supervision of experienced craftsmen, most firms make provision for apprentices to be released during regular working hours to attend technical classes one or two days a week, or sometimes they attend in the evening. In other cases such release may be accumulated for a "block release" for several weeks at a time. The line between apprenticeship and technical education grows even less distinct in the full-time courses offered by some technical colleges which provide the first year of apprenticeship training, just as this first year may also be provided by the Ministry of Labour at the Government Training Centres (28).

At the same time, industry has steadily increased its provisions for training since 1945. More than 120 industries or sections of industries have established apprenticeships and other training programs, most of which train craftsmen for the traditional skilled occupations, but some have also been introduced for semi-skilled occupations and for technicians. Apprenticeship programs are regu-

lated at national level by a joint council or board representing organized employers and workers in the industry, such councils often operating through joint committees which keep in close touch with local education authorities and the Youth Employment Service. Many large companies have full-time courses of practical training in apprentice training schools where apprentices may spend up to two years, but most apprentices are trained by firms with no special facilities other than training on the job under a skilled workman.

New types of apprenticeship training are emerging. At the higher levels, apprentices are more and more often entering full-time university or technical college courses preceded and followed by practical training, or "sandwich" courses in which there are alternate periods of full-time study and practical training over a period of three or four years. Technical education increasingly provides also for training as operatives on levels of skill lower than that of craftsmen. Industry is encouraging the development of technical education at the university level by endowing chairs, making gifts of money and equipment, and providing scholarships for study and research in science and technology (28).

The highest proportion of the handicapped who become apprenticed are the deaf—about half of them. Next in frequency come those with a disability of the lower limbs, and then those with partial sight, of whom about one out of four becomes apprenticed. The lowest proportion is found among the epileptics and the ESN. The high proportion among the deaf and the blind indicates the amount of attention devoted to them, and the attention directed to the earliest years of their education instead of being postponed until the adolescent years (95).

There are several reasons why apprenticeship training is not as readily available to handicapped youth as to normal youth, quite aside from the limitations imposed by a disability.

(1) There are too few opportunities for apprenticeship training, even for the able-bodied. The government report "Education in 1962" pointed out that in that year a little over a third of the boys under 18 leaving school entered apprenticeships; this left a large number unprovided for, with the situation for girls even worse than that for the boys. This occurred "at an age when an abrupt end to formal education erodes the benefits already gained in general education as well as sacrificing the chance of acquiring craft skills" (175). Actually the number of boys obtaining apprenticeship has declined as a whole (119). The percentage decreased from 36.2 in 1962 to 33.5 in 1963, and there was a similar drop for girls from 7.2 to 5.5. There was also a decrease in the number of young people entering other employment offering systematic training for one or more years. Some believe the decreases must be explained in large part in motivational terms, while others continue to stress lack of

suitable opportunities. It is also asserted that large firms are less willing to accept disabled trainees because they anticipate difficulties arising from pension provisions (286).

(2) The requirements for acceptance into apprenticeship remain too rigid. In evidence presented to the Newsom Committee in March 1962, the National Union of Teachers recommended that there be greater flexibility in the age at which apprenticeships begin so that young people are not forced to choose between accepting an apprenticeship and staying on in school to complete a five-year course; apprenticeships should certainly not be offered before the age of 16 (277, 342). An apprenticeship that does not lead to placement is regarded as worse than useless, and therefore it is considered important that the necessary preparatory training be received during the school years. But the handicapped youth is often less likely to be able to acquire the preliminary training specified by an apprenticeship program. Also stipulating a training period of a given length without taking individual circumstances into account creates a disadvantage for the handicapped school leaver. Since he is a little older than normal apprentices on beginning his training, he may not arrive at the point of receiving an adult rate of pay quite as soon as normal apprentices (95).

(3) There is lack of clear identification of jobs whose apprenticeship training requirements could be mastered by the handicapped. The problem of adequate apprenticeship training for the handicapped could be tackled more scientifically if industry would cooperate by identifying those jobs within the capabilities of particular types of disability (95).

Only recently has the government attempted to undertake some regulation of the training offered by industry. Until the passage of the Industrial Training Act, 1964, the Ministry of Labour assumed largely a "hands-off" policy so far as this training was concerned—whether the company gave such training or not, and the amount and nature of the training provided. The new Act (118) represents an attempt both to encourage and to regulate such industrial training. The Act empowers the Minister of Labour "to establish industrial training boards and to give those boards certain responsibilities for the promotion of training." Each board must provide training courses and make recommendations concerning the nature, length, and standard of training. It has the authority to apply tests during and at the end of the training period. It will charge a levy, likely to be substantial, on each firm in the industry and pay a grant to any firm which provides approved training courses. The boards will consist of equal numbers, probably five each, of representatives of employers and workers, an independent chairman, and three members representing educational interests, with assessors appointed by the Ministries of Labour and of Education.

This leaves in control the two sides of industry which have so conspicuously failed to achieve anything like adequate results in most industries up till now. No places have been kept for independent experts. The chairman will have to be persuasive, especially as voting on the levy is restricted to the employer-worker groups . . . In Parliament and elsewhere attention has been drawn to the difference between the Government's acceptance of the Robbins principle "that courses of higher education should be available for all those who are qualified by ability and attainment to pursue them and who wish to do so," and the absence of a comparable declaration for the much larger number—over half each age group—capable of receiving industrial or other training. The Ministry of Labour argues that the levy will have such an effect that its adoption amounts to a principle (119).

The boards will be empowered to provide training courses themselves and to enter into service or apprenticeship contracts with their trainees. A network of regional and local offshoots of industrial training boards will be established. Apprenticeship committees already exist, but the boards will have to see that they become more effective.

A good supervisory staff is obviously necessary, with advisors to help obtain good training standards. So far there has been no consideration of the extra load that technical colleges will be called on to carry; many are now working to capacity and government training centers are few and far between. Even though boards have been promised £50m. in grants and loans, establishing their own centers might mean delays in obtaining buildings and equipment when required simultaneously throughout the country. Also few firms can expect to have their present training programs approved without change. The levy will not necessarily make the smaller firms less reluctant than in the past to take on apprentices. Shortage of instructors could also hold up expansion.

"With the rapid and drastic changes in the skills required in industry because of automation and specialization, continuous review of training requirements is necessary and a great deal more information and knowledge must be collected and assessed," such as the data being collected currently by the Manpower Survey Unit of the Ministry of Labour and the National Economic Development Council.

While welcoming the Act, one should, over the next few years, consider carefully whether another Act will not be required which will regard industrial training as part of a general educational process in which every young person with ability and interest has the right to take part (119).

Many experts feel, however, that the specific problem of helping both normal and handicapped youth to prepare for and find employment involves more far-reaching changes than those envisaged in the Industrial Training Act. First of all there must be a careful examination and evaluation of the changes occurring in the total labor market. John Wellens, in "The Training Revolution," contends that England has had a nineteenth-century perspective in what he considers to be an over-emphasis on expanding apprenticeship opportunities, concentrating on changes such as prescribing three years rather than five as the normal length of the training period, and lowering the age of entrants.

Viewed objectively, the pressure to increase the number of apprentices places very often resembles a rescue operation for the boys themselves, independent of the needs of the industrial and economic situation. It may well be—and in the absence of facts we shall never know—that where society needs more of its intelligent and highly-skilled workers is higher up the employment ladder (394).

The program of occupational training, says Wellens, must be organized so as to provide a balanced labor force based on careful prediction of future needs. The government rather than industry should take the lead in establishing a program called NOCTA—a National Occupational Training Authority—to determine labor needs in terms of the changing economic picture, and then to specify the program of training and the number of apprentices or other types of trainees to be accepted at a particular time. Furthermore, he recommends the "spectrum" approach, in which the nature and length of the training, including apprenticeship training, varies according to the demands of a particular kind of job, rather than having a blanket rule such as applies to apprenticeships today. Job analysis, carefully specified programs of training, and adequate supervision are all important, and in these respects he feels that the U. S. has made more rapid progress than England.

The old apprenticeship practice called "sitting next to Nellie" or working with an older craftsman has had many disadvantages and shortcomings. It lasts for five years regardless of whether the trade is a simple one like house-painting or a complex one like cabinet-making. There is no certification of the qualified craft-worker at the end of apprenticeship; since there is no national control over apprenticeship there is no inspection and no uniformity of procedure or trainee product. There are rigidly prescribed lower and upper age limits, with very limited escape clauses. It is not necessary to pursue an academic or theoretical course along with the practical training. A further characteristic which Wellens considers a serious limitation is that training is invariably for a single craft, whereas

one of the great needs of modern industrial society is for multi-skilled craftsmen.

The English apprenticeship system dates back to 1563. By the beginning of the nineteenth century the system was disintegrating, but towards the end of the century the practice was revived, in contrast to the complete reorganization of the system in Europe and in America. The Commission of the Common Market has made some far-reaching proposals for member countries involving a thorough overhauling of the apprenticeship system along the lines Wellens suggests, although to date England has done little in that direction. He considers the Industrial Training Act 1964 a weak and half-hearted effort which still relegates most of the responsibility and initiative to industry rather than to government. There persists the harmful split in responsibility for training the young worker between the Department of Education and Science, controlling further and technical training, and the Ministry of Labour, controlling more specific vocational training in government training centers and Industrial Rehabilitation Units. Meetings between educators and industrialists are no substitute for long-range central planning.

A closer welding of academic education and vocational training is necessary in order to produce the larger numbers of more highly skilled and managerial figures needed in today's industrial situation. This means breaking down the snobbish distinctions between grammar-school and university education on the one hand, and technical and vocational training on the other. For too long industry and technology have lacked respectability in English society. The highly skilled professional engineer, for example, usually has a more respected role in other societies than in England.

How such changes, if they occur, would affect handicapped youth cannot be predicted at present. It seems reasonable to assume that as higher-level and more highly skilled occupations open up for youth in general, with a broader range of training opportunities, the prospects for handicapped youth should also become more favorable. For the time being, however, they are faced, like normal youth, with the traditional apprenticeship system. Only one-third of all boys leaving school between the ages of 15 and 17 (school leavers from secondary modern schools and early leavers from grammar schools) start on a formal system of training, whose weaknesses Wellens has discussed. More than half (the non-apprentices) enter semi-skilled occupations in which for the most part they receive little or no training. The remainder, less than 10% of the total, enter clerical work for which there is no nationally accepted program of training. It is difficult to obtain comparable figures for girls. An often-quoted figure is that one girl in six in the 15-to-17 age range receives training for a period of about one year, though the actual figure could well be as little as one girl in sixteen. Thus for girls

in general, commercial workers, and non-apprentices, who altogether make up three-fourths of the schools leavers entering employment, there is practically no formal or recognized kind of training, and certainly no compulsory training. Some firms, such as a few in the steel industry, do make possible some efficient technical training for new employees, but these are the exception rather than the rule.

Later school leavers have better training opportunities, whether through day-release study, evening study, block release for six months or so, or sandwich courses of longer duration, depending on the vision and the financial resources of the company concerned. Small firms, however, do not do their share of such training, and need direction and assistance in terms of some overall organization. More of the late school leavers continue with full-time education in universities and colleges, with academic instruction often combined with practical occupational training. "The cards are stacked in favor of the people who stay longest in the educational system before taking up their first job" (394). As indicated earlier, management training is less effective than in other countries such as the U. S. and France, and training for foremanship and supervision is seriously lacking.

CORRESPONDENCE COURSES

For hospitalized and homebound youth and adults there are available correspondence training programs organized under public and private auspices. A central agency for putting the disabled person in touch with a particular correspondence program is the British Council for Rehabilitation of the Disabled, which reported in 1964 that over 1,000 patients were currently in training in such programs. The wide variety of courses provided by various groups range from accounting, advertising, and agriculture to watch and clock work, window dressing, and woodwork draughtsman. In a survey of courses arranged by the Preparatory Training Bureau since 1953, a sample of 114 cases revealed that 74 had completed the courses and 19 are continuing them. Some went on to Ministry of Labour courses in workshop practice, center lathe turning, and radio servicing (11). The number of courses arranged during 1962 was 264, bringing the total enrollments since the beginning of the service to 4,871 (9). Payment for the courses is made by local education authorities, the additional administrative costs coming from voluntary funds.

These Preparatory Courses serve varying needs in hospital patients: the continuation of study interrupted by illness or accident; the initial choice of a career; refresher work in an occupation to which the person will return; choice of a different occupation in the case of permanent disability. The first application for training under this program is usually received through the hospital almoner, often

in collaboration with the occupational therapist or in some cases the doctor, who gives advice and assistance in the arrangements made for his patient. Close cooperation exists with the Ministry of Labour, sometimes the Disablement Resettlement Officer specifically (11). Some local education authorities send Assessment Officers to visit prospective students to assure full use of the facilities of the bureau, and to help students find the type of course best suited to their needs, whereas other authorities themselves recommend a particular training course to follow correspondence work in further education which they have provided.

In order to assure adequate encouragement and assistance for the student, progress reports from medical social workers, almoners, or psychiatric social workers are found very helpful (11).

An example of the kind of help given through a correspondence training program is the following:

In August, 1961, we were asked to help a young boy of 19, an epileptic, by providing lessons in Arithmetic to help with his work in a wine shop—he was unable to attend evening classes and did not earn enough to pay a private tutor. We laid out a course of lessons and this was followed by further courses. He managed to keep his job and now has a full working knowledge of weights and measures, calculations, handling crates of bottles, understanding odd and even numbers and also money calculations. His greatest handicap was his inability to mix and his tendency to withdraw. This he has overcome and he is now a very proud member of his local Youth Club at which he plays his guitar (9).

VOCATIONAL TRAINING FOR SPECIFIC GROUPS

Vocational training for the blind is provided, as for other disabled persons, for the professions and for industrial, commercial, or sheltered employment, according to the aptitudes and characteristics of the individual. Training costs are paid by the Ministry of Labour, and maintenance allowances are payable to those in training, if they are receiving wages. For the professions, the course of training and the examinations are normally the same as for the non-handicapped. Special courses are available in music, and the only approved training course in physiotherapy is that of the Royal National Institute for the Blind. Training for industry and commerce may be in employers' establishments, at special centers, or at a general training center, wherever the best training in a particular specialty can be secured. In employers' training programs, specialist training officers are provided for the blind by the Ministry of Labour and the RNIB. Training for sheltered employment is provided chiefly in Workshops

for the Blind (286). The RNIB also provides a special training college in London for blind shorthand-typists and telephonists. The telephony course lasts 3 to 5 months, the shorthand-typing course 12 months, and the recorder-typing course 6 months. These courses are approved by the Ministry of Labour, which pays fees and training allowances. Students are encouraged to find amusement outside the training college, and to share recreational activities with their sighted friends. Many of the students come from small towns and villages, and since they may find work in large cities, they need to become capable of leading an independent life (324).

The Royal School for the Blind at Leatherhead accepts blind people with other disabilities. It provides training for employment, and employment facilities. There is occupational craft work with residence for young blind persons who appear unsuitable for industrial training and who might otherwise drift into residential homes designed mainly for the elderly. The training may in some cases lead to full-time training elsewhere, and then to employment.

Training may be given at home by special teachers provided by two of the Regional Associations for the Blind. The deaf-blind are a special problem; they are taught a manual alphabet by home teachers trained under the same auspices (286).

Local authorities are empowered to extend services for the blind to registered partially sighted persons. However, special residential rehabilitation facilities and certain residential training courses providing training for blind persons by "blind" methods, such as the teaching of Braille shorthand, are not available to partially sighted people generally, but only for those who are likely to go blind within four years of registration. This raises a problem for partially sighted persons whose prognosis is uncertain or whose needs cannot be met fully by rehabilitation and training with fully sighted people on the one hand or with blind people on the other hand. The Ministry of Labour accepts for its training schemes those covered by a suitable medical certificate or who on leaving a school for the partially sighted have difficulty coping with the demands of everyday life. Some provision is made for the partially sighted at the Royal National Institute for the Blind, within the limits of its charter (286).

Since the number of blind school leavers is very small, it is only occasionally outside large cities that the youth employment services are called upon to place such a youngster in employment. Training for them usually lasts three or four years, but those permitted to take shorter courses in telephone operation, typing, or light engineering will be available for work before age 18, and hence their placement will be made by the youth employment officer. The partially sighted are a larger group, of whom over half suffer from myopia, with a risk of further deterioration. In some cases they may be as handicapped as those classified as blind. Telephony and emi-dicta

typing are considered suitable work for them, but not heavy manual work (47).

A recent change of emphasis in the vocational training of the blind has occurred. The Ministry of Education, in consultation with the Ministry of Labour, considered the report of the working party on Workshops for the Blind, in which several recommendations were made which were designed to bring about a progressive shift from traditional handicrafts to modern machine production in the workshops offering sheltered employment for the blind. This would mean that in the future a blind person to be provided with employment in a sheltered workshop would normally undergo a relatively short period of training in the skills required by the production methods of his own workshop instead of having a long period of training in skilled handicrafts. Hence the working party recommended that all vocational training for the blind be given in workshops, but that it should not normally begin before the age of 18. The working party commended the work of the Hethersett center sponsored by the Royal National Institute for the Blind, and suggested that all blind youth leaving school at age 16 should have the benefit of such a course, which could provide further education and vocational guidance in addition to a general preparation for the responsibilities of adult life (176).

The Ministry of Education accepted these recommendations, and thereupon notified the voluntary groups which provided training courses in the traditional handicrafts for blind boys and girls aged 16 to 21 that the Ministry would no longer give official approval to these courses. This decision in some instances ended a long period of service for the institutions concerned, but such efforts to modernize the education and training arrangements of the blind were welcomed because of their furthering the interests of the blind. The Ministry was also giving consideration to further steps for adding to existing facilities for the further education and pre-vocational training of blind youth aged 16 to 18 (176).

In the vocational training of deaf youngsters, there is considerable controversy as to whether training in one of the 30 trade schools provided for them on either a part-time or full-time basis, or apprenticeship training would give them the better employment opportunities. Some prefer to train the young person in trade schools and then offer them to employers as journeymen, with the obvious advantages of thoroughness of training and the maximal development of skill in a situation adapted to meet their special needs. But others argue that the deaf are thus limited to the few trades taught in these schools, whereas apprenticeship in industry offers the whole range of trades suitable to individual ability and aptitude. Also, learning in a normal situation accustoms the youngster to the environment in which he will be earning his living. Since some employers demand attendance

at evening classes, however, deaf apprentices are placed at a disadvantage unless there is specially adapted instruction provided for them (403).

Some writers deplore the lack of attention to the specific vocational needs of the deaf. They believe that there is too much emphasis on stereotyped concepts of "jobs suitable for the deaf," such as tailoring, shoe-repairing, and baking. The vocational "undergrading" of the deaf is more noticeable in the case of those with average or superior intelligence or outstanding ability. Problems involved may include: physical difficulties such as use of the telephone; inability of the individual to communicate quickly enough, and hence lack of promotion in administrative positions which entail considerable committee work; or job emphasis on interpersonal relationships. It has been pointed out that suitable training facilities on a technical or university level are lacking for the deaf, even though there is no reason why many scientific and technical jobs could not be performed by deaf persons. A small specially trained staff in various institutions for further education to deal with the instructional needs of the deaf is needed (363).

Deafness does in general rule out work, however, in which contact with people is an essential part. The work most successfully undertaken by deaf school leavers includes work of a practical or craft nature taught by visual methods. Intelligent deaf girls can undertake typing or work as machine accountants (47).

Various voluntary groups have attempted to help deaf youngsters meet the problems imposed by their disability. Among the many services provided by the Royal National Institute for the Deaf is a training center for maladjusted deaf young men where they are taught trades and hobbies in addition to enjoying opportunities for sports and learning self reliance and approved social behavior. Many contacts with the hearing world are made possible through the medium of participation in groups such as Senior Scouts, Youth Clubs, and Quaker Work Camps (334).

To help deaf apprentices who must take training in technical colleges, the Royal National Institute for the Deaf and the National College of Teachers of the Deaf can arrange for a qualified teacher of the deaf to act as interpreter (47). The National Deaf Children's Society, in a policy statement agreed upon by the National Council in May, 1959, stated that its aims in the service of school leavers were: (1) to try to obtain an additional year of compulsory schooling for all deaf children, until the age of 17; (2) to establish, when financially feasible, an institution which would include provisions for the training of deaf school-leavers; (3) to explore the possibilities of more time for vocational training in the last year at school, and instruction in "Civics"; and (4) to support the establishment of County Youth Colleges for the Deaf (258).

Most spastics who enter employment do so without previous training. Few are able to benefit from vocational training courses available under the Disabled Persons (Employment) Act. Their training must take into account the need for social adjustment. Most could benefit from long-term assessment and training for employment. Specific job training such as given by Tickopres Ltd. in London to severely disabled young persons in the use of their overprinting machines could open other avenues of employment (46).

The center at Sherrards, Old Welwyn, Hertfordshire, is the first residential training establishment in the world exclusively concerned with the industrial training of the cerebral palsied. Training is provided in a number of vocations including light engineering and wood-working. A commercial course and a domestic course are to be added. The present capacity of 31 men and women is to be increased with new additions (355). A training center for emotionally disturbed spastics is in the planning stage; at present some of these young people are referred to regular training centers, but they disturb the other trainees. The proposed center might be located south of London, near psychiatric and medical facilities.*

The Spastics Society, through its Careers and Employment Department, provides certain kinds of training for the cerebral palsied who cannot find employment without such specialized training, or who fall below the basic standard required for certain employment: light engineering and woodwork; commercial work, mainly routine procedures and the operating of the less complex office machines; operation of label overprinting equipment; domestic work; and general training for social independence and adjustment to help the cerebral palsied mature by spending some time away from home (357).

For the tubercular there are seven village settlements, four run by voluntary organizations, and three run by local authorities. Most of them offer long courses of rehabilitation combined with industrial training leading either to open employment or to sheltered employment in the settlement. The Ministry of Labour pays part of the cost of these courses, provides maintenance allowances for the trainees, and makes grants towards the cost of providing sheltered employment as for other disabled groups (286).

Where epileptics are accepted for training, their percentage of successful completion of such courses tends to be lower than for other forms of disability. The Portland Training College for the Disabled, in reviewing 21 epileptic cases accepted between 1953 and 1959, found that 52% had completed their course of training, in comparison with an overall record of 83% for all forms of disability accepted into training (300).

* Interview with Mrs. C. Clifton, Spastics Society, July 1963.

"TRAINING" OF THE MENTALLY HANDICAPPED

A final word should be said about the use of the word "training" in connection with the mentally handicapped. It was pointed out earlier that whereas the special provisions for the educationally subnormal are classified as education and are offered by the local education authority, the provisions for those with lower IQ's who are considered unsuitable for education at school are classified as training and are offered by the local health authority. In the case of the mentally subnormal, then, there is no clearcut distinction between the earlier pre-vocational experiences provided for children and youth on the one hand, and specific vocational preparation and placement on the other. Three main types of training centers for the mentally subnormal are (1) for juniors under 16 years of age; (2) for adults 16 and over; and (3) for all age groups. Vocational training in preparation for employment is more likely to be provided in the second and third types of center; both this kind of training and actual employment may be offered in the same center, or in some instances the training may lead to open employment. In other words, the centers for adults include both those with limited ability who will need permanent sheltered employment, and those who eventually will find jobs in the open labor market (218). Provisions for the mentally subnormal are discussed in a separate section as part of the total welfare services available for the handicapped.

One indication of the fact that the line of demarcation between training and education is gradually blurring is found in recommendations coming from Dr. Gunzburg, who maintains that even with the adult subnormal a program of education, more broadly conceived than at present, is needed rather than specific training as such (87, 88, 89, 90, 91).

A good example of meaningful training for mentally subnormal adolescents is that of the training center and hostels maintained at Slough by the National Society for Mentally Handicapped Children. This organization stresses the idea that many children coming from the junior training centers cannot be trained as a behaviorist psychologist might train a rat or pigeon, but can be helped to lead socially meaningful lives in the community (377). One young man with an IQ of 41 came to Slough when he was 17½ and after only 30 weeks of training, his records showed an immense improvement, especially in social behavior and general reliability. There are 30 residents at Slough, and the 15 boys and 15 girls live in separate hostels connected by a spacious and well furnished common room. The working day at the center is from 9 to 5, during which time the youth do not return to the hostels.

The workshop itself is a striking contrast to the sort of senior training center where severely subnormal young peo-

ple of pathetic, premature senility pick desultorily at a few simple handicrafts.

Instead, the youngsters are all busy and happy, whether working at simple tasks like filling flower pots with prepared soil, working at more delicate jobs such as neatly packing advertising calendars, or expertly handling a machine. The site of the center was chosen because of the industries in the area which could provide various grades of contract work. These firms have been very cooperative, and some have provided fairly complicated and expensive machinery for the work they want done. When a youngster's records indicate consistent efficiency and reliability, along with a fair work speed, he is sent out to work for a firm. At first he remains a trainee, receiving spending money from the Association, but if he passes this probationary period successfully, he is hired as a regular member of the working community. But even if a youth does not reach a high level of skill he does acquire greater self-reliance by learning how to make complicated trips by himself, handle money, and use a telephone.

The present-day institution or mental hospital for the subnormal must provide not mere busywork but workshop training in fundamental skills which will be needed by the retarded in finding a job in the regular labor market. These basic skills which are a common denominator valid for all work situations are timekeeping, attention to tools and materials, maintenance of steady speed, rate of production, and especially relationships with other people. The subnormal thus develop better work attitudes and work habits which enable them to hold down a job eventually, for the problem is usually more that of *retaining* a job rather than that of *obtaining* it in the first place. Failures are often shrugged off as the result of immaturity and instability, just as the low IQ itself used to be considered a valid reason for failure. But the basic question presented is how such immaturity and instability developed, and what can be done to correct them. Counselling which helps the subnormal to understand and interpret community regulations and customs is actually a form of education in a broader sense than is implied by purely academic subject matter, and therefore educational approaches and aims are being reexamined, to be sure that they include the kinds of understanding and help which the subnormal person needs. Social competence is a more important concern than illiteracy. This social competence is furthered by the acquisition of a certain amount of educational knowledge, but it can be decreased considerably if the acquisition of this educational knowledge requires a lengthy institutional stay. For social competence in community life must be learned in the community; it cannot be learned in the artificial life of the institution (90).

Reexamining curricular material from the point of view of social competence means, for example, that learning to read a book or newspaper is found to be less important than learning to recognize

and obey a "Keep Out" sign; writing a letter is less important than writing one's signature in the right place. The subject matter of books must deal with practical situations such as encounters with landladies, shop assistants, bus conductors, foremen, postal workers — not with cowboys and robbers. In other words, books must deal with the subnormal person's very own problems in adjusting to community life. Education of the adult, with so little time at its disposal, must concentrate on the minimum of essential knowledge which is in daily use for communication purposes. Occupational or industrial training as such is no substitute, especially since it is learned within the institution, and cannot really help him to adjust to the multitude of everyday situations he will face outside. In the form described, education can become the most valuable single therapeutic factor in the total process of rehabilitating the adult subnormal.

Dr. Gunzburg, consulting psychologist at the Monyhull Hospital in Birmingham, has helped to develop at this hospital a series of educational readers published in 1961 under the title of "Spotlight on Trouble" to serve the purposes he described above. The syllabus of a three-months "Educational First Aid" program is found in his book on "Social Rehabilitation of the Subnormal" (90).

The traditional occupations of mental institutions are acceptable for those who need only custodial care, but are not suitable for the subnormal persons with the capacity of returning eventually to the community and some form of regular employment. There are several reasons why this is true: (1) Basket-making, mat-making, and other forms of arts and crafts are seldom regarded as work by people who have been in "man-sized jobs." The small scale of production in the institution makes it impossible to give this type of occupation any atmosphere of urgency and industriousness. (2) No real improvement in skill or speed is either aimed at or encouraged, for most institutions find it nearly impossible to dispose of the products and recover some of the cost of materials. When it does not really matter how much is done or how quickly it is done, this is poor preparation for later piecework jobs. (3) Tools and methods of work are usually as old-fashioned as the occupations themselves. The most congenial tool for the subnormal individual is the machine which requires no thinking or skill and enables him to produce finished, faultless articles, but machines have only recently been introduced into a few progressive institutions. (4) Most arts and crafts necessitate the production of a completed item by one person, but this automatically limits the range of crafts to a few simple ones which the subnormal is capable of mastering (90).

Thus the skills acquired provide some occupation for leisure hours later on but are not a preparation for the world of work, because the methods of training are out of touch with reality. Work in maintenance departments such as bricklaying, painting, and laundering does

provide more normal work pressure, but the need to get the work done in the most economical way makes the training of the sub-normal an incidental and secondary task. New arrangements for training must consider (1) what particular capacities are in need of training, (2) for what type of work they should be trained, and (3) what is the maximum efficiency that can be expected. Even methods of teaching young women domestic work often fail to prepare them for work outside the institution, for they may find it hard to transfer what they have learned in the large institutional wards to the small average household.

Even such ordinary processes as dusting and sweeping assume different guises, and may be frightening when they are done in an over-furnished suburban house after inadequate "training" in a bare ward containing little else but a row of iron bedsteads.

Girls who are temperamentally unsuited to domestic work are happier in factories and should therefore be given some preparation for this kind of work (90).

The current tendency to introduce industrial processes as a replacement for traditional crafts is of little value if they are merely a substitute for the other activities. "There is no essential difference between making rugs or brushes and folding cardboard boxes or filing aluminum castings," without concomitant training in particular work habits and attitudes, for these are not automatically required by the introduction of industrial processes. Careful study must be made of the types of work which are suitable, and the ways in which the necessary habits and attitudes can be taught. Only work so taught as to aid in rehabilitation for life in society can be designated as training, and such work is all the more useful and helpful if it does not impose a considerable financial burden on the institution, and if it is remunerative and results in saleable articles. Everyone must co-operate to make such a program effective—doctor, nurse, supervisor, trainer, counsellor, and teacher (90).

Chapter 5.

Employment Services

GENERAL PROBLEMS

The importance of work in providing the individual with a sense of personal worth has long been recognized in western society.

Our surnames are all derived from one of three sources — patronymics, place names and occupations. It looks as though our family, our place of origin, and the work we do, are the three important elements in our very sense of identity (244).

Obtaining satisfactory employment is often of more critical importance to the handicapped adolescent than to the non-handicapped adolescent not only as a means of proving personal worth but also as a means of asserting his independence of adult supervision and authority, especially if he lives away from home, because of the difficulty he has experienced throughout his life in achieving such independence.

The handicapped youth obtains a job from the usual procedures of answering advertisements and following leads provided by friends and relatives, but in addition he may use the services of the youth employment officer, of the Disablement Resettlement Officer if he is severely handicapped, and of voluntary organizations, many of which provide special help of this kind for persons with particular kinds of disability.

The disabled youngster may have special employment advantages which include a provision of the Disabled Persons (Employment) Act, 1944, that any firm hiring 20 or more persons must employ a 3% quota of handicapped persons. Many employers exceed this quota voluntarily. However, the wisdom of specifying certain occupations for the disabled is questioned. So far the only forms of employment reserved for the disabled are those of car-park attendant and electric passenger-lift attendant. The Ministry of Labour is reluctant to specify many occupations like this for the disabled lest the impression be given that they can perform only low-grade forms of work (93).

Supply and demand factors in the labor market are especially important to handicapped youth. There may be a general shortage of jobs, or a shortage of the kinds for which the disabled youth is able to prepare himself. Technological changes are occurring so rapidly that the job he learns to perform (such as hand-packaging) may be taken over by a machine, or the nature of the job itself may change so much that the youth must readjust to the work situation. The social satisfactions of working in small groups in close proximity to other people may be lost; for example:

Where before there were groups of people doing manual work, there are now two or three people scattered over a large area controlling dials, controlling quantities and qualities of materials, and where a mistake cannot be made (244).

Not only is the worker more isolated, but he must accept greater individual work responsibility, an increased pace of production, and continuing change in his pattern of work. Even office work is becoming mechanized and impersonal, resulting in the physical separation of persons who were accustomed to being grouped together. While these problems face all youth, the handicapped often find it more difficult to adjust to such changes.

In one survey of the employment of handicapped youngsters, a total of 3,059 handicapped youth from Scotland, England, and Wales, which represented 3.6% of the total school leavers in their areas, was checked for the five-year period following their last year in school (1954-55). The sample was drawn from 83 areas, both urban and rural. In this sample, 4% of the school leavers attended grammar schools, 25% attended special schools, and the balance attended secondary modern schools. The largest disability groups represented in the survey were the delicate and the educationally sub-normal: 35% of the girls and 27% of the boys were classified as delicate, while the ESN constituted 21% of the total. The other disability groups were all relatively small in number.

The results showed that 96% had obtained a satisfactory start in employment. "A reasonably satisfactory start in employment" was defined as a start regarded as reasonably satisfactory by the handicapped school leaver himself, his employer, and the youth employment officer. The five-year period studied allowed the youngsters a reasonable length of time to become settled in jobs, and also provided an interval of good general employment opportunities. Of the 96% who made a satisfactory adjustment, 19 in every 20 entered regular work, and of the small remainder about half entered sheltered employment. Also about one in four of the handicapped boys under 16 years of age entered apprenticeships as compared with one in three of boys in general. About one boy in twenty took up clerical

employment, a ratio identical to that for the non-handicapped. Even in areas reporting a shortage of jobs, it was indicated that most of the handicapped boys and girls had achieved a satisfactory start (209).

A special committee of the British Council for Rehabilitation of the Disabled were concerned, however, that the results tended to give "an unjustifiably reassuring impression of the situation" regarding employment of the handicapped school leaver (10). They questioned the suitability of the sample and the assumptions on which statistical treatment of the data was based. While stressing the usefulness of the information provided by the survey, they emphasized the fact that an employment problem does exist for handicapped school leavers.

The need for better coordination of existing services to place handicapped youth in employment and to follow their progress after placement has been recognized for many years, and is a constant theme in many publications. A number of reports have recommended that some new integrating service be established to bridge the gap between school and job, a service more closely affiliated with industry than is the present youth employment service. Kershaw, drawing on his experience as an Appointed Factory Doctor, has pointed out that while the transition from school to job often involves severe strain for normal children, the strain is even greater for handicapped children. Yet just at the time that they most need help, they pass out of the care of the people who know them best, and whom they know best. The growing welfare services of the local authorities must still learn how best to serve handicapped adolescents in the transition stage (139).

A program of after-care is needed for the handicapped school leaver in order to assure a more effective transition from the school to life in the community. After-care means follow-up to check on the progress of school leavers in various communities, whether they enter open employment, work in sheltered workshops, are employed in a homework program, or remain in custodial care with activities that constitute occupational therapy rather than actual employment.

After-care services have already been provided by some local education authorities. The London County Council, acting through its Education, Health, Welfare, and Children's Committees and in conjunction with various voluntary organizations, provides a comprehensive service of follow-up and after-care for all handicapped children (113). The arrangements vary according to the type of handicap and the needs of the individual child. Review of the progress of school leavers up to age 18 is the responsibility of the Youth Employment Service. Some categories of handicap are dealt with directly by the Handicapped Young Persons Section of this service, which is the clearing house and coordinating unit of the Youth Employment

Service for all handicapped youth. Employment progress is determined through inquiries to employers, letters to the young people themselves, or invitation to the weekly open evening at the local Youth Employment Bureau. Special sub-committees of the youth employment committees in London, which meet two or three times a year to receive information about the post-school activities of handicapped youth, take further follow-up action when it seems necessary. The Handicapped Young Persons Section has specialist officers who work in close cooperation with the Care Committees, with other departments of the Council, and with voluntary organizations for the handicapped. The youth employment officer refers to the Chief Officer of the Welfare Department those handicapped young persons who need the general welfare services provided by his department, advises them about registration as disabled persons with the Ministry of Labour, and consults the Disablement Resettlement Officers when necessary. At the age of 18 these young people become the responsibility of the Ministry so far as their employment is concerned, and those who are registered as disabled are advised to seek future help from the Disablement Resettlement Officer, who has already been given information by the youth employment service about individual employment problems (113).

The children's care committees, which are uniquely a London provision, include among their other functions the working with youth employment officers to help bridge the gap between the secondary school and the adult world. The volunteers serving on these committees try to become accepted non-official family friends, ready to help at all times and to give information about the availability of other forms of assistance. They follow up school leavers in various ways, such as by visiting homes to give help and advice and by arranging for help from the different statutory and voluntary services for the handicapped (150). A care committee is connected with every primary, secondary, and special school, or group of such schools. These volunteers also cooperate with the Children's Committee, which is responsible for the general welfare of handicapped children in care and for follow-up and supervision when they leave school (111).

Liverpool also has well developed services of this kind. Each special school has its own After-Care Committee to assist the Head Teacher. The aim is to visit and advise parents in order to be sure that children continue any prescribed treatment, and are happy in their work and have satisfactory working conditions. When a youngster is unhappy in his job, or the work is unsuitable because of his physical disability, efforts are made to arrange a change of employment (148).

After-Care Committees in Liverpool cooperate closely with the Handicapped Section of the local Youth Employment Bureau. All boys and girls are invited to come to the Bureau for an evening visit

about three months after starting their first job and subsequently if a second position or still other posts have been found for them. During a recent six-month period, 81 boys and girls responded to these invitations, 70 personally and 11 by written replies. A further 31 attended an "Open Evening" on their own volition to get further advice. Since about half the youth fail to respond to the invitations, the staff try to make further contact with them by means of home visits—69 such visits were made either in connection with after-care, to make contact with parents, or to help and advise homebound youth. Improved parental cooperation is one of the most important outcomes of these visits. Although only 46 of the 110 boys and girls interviewed in special schools were accompanied by their parents at the time of the interview, 141 parents called at the Bureau, in most cases on the occasion of the youngster's first visit (149).

In a report on youth employment in Liverpool for a six-month period ending January 31, 1963, it was found, as elsewhere, that decreasing employment for youth in general works a special hardship for the handicapped.

When the employment situation is difficult the group which suffers most grievously is, unfortunately, that which is least well equipped to bear it, namely the mentally or physically handicapped (149).

Therefore the past six months had been especially frustrating for the Handicapped Section of the Youth Employment Bureau. Added to the total of those who needed suitable initial placement were those who had lost their jobs. It was therefore considered important that every effort be made to encourage those already placed to keep their jobs. Letters were sent to parents at the time the young people commenced work, asking them to cooperate in ensuring regular and punctual job attendance, and to seek immediate consultation with the Bureau if any difficulty should arise in connection with the work. The purpose was to enable the Bureau to intervene to avoid loss of work resulting from any minor dissatisfaction or misunderstanding which could easily be rectified.

Limited employment opportunities may make it necessary for handicapped youth to accept jobs not ideally suited to them, jobs on a lower level of skill than they were capable of handling. Such youth are urged to keep in touch with the Handicapped Section of the Bureau, through its weekly "Open Evening," so that when the opportunity came, a better position could be found.

During the year ending January 31, 1963, a total of 382 handicapped young people (223 boys and 159 girls) were given help and guidance, an increase of 73 over the previous year. Of these, 147 boys and 104 girls had attended the Education Committee's special schools up to the age of leaving. Some of the remainder who had

completed their schooling in ordinary schools had also spent some years in a special school previously. Half of the boys and girls were educationally subnormal (149).

The youngsters who posed the most acute problems were the epileptic, particularly those with temperamental difficulties, and the mentally subnormal with poor physique. With an ample supply of job applicants, many employers were less tolerant of the slower child who requires a longer learning period and who may never be able to achieve normal standards of output. During the 6 months 196 vacancies were filled by handicapped youth (102 boys and 94 girls), a decrease of 50 as compared with the year before, because of increased competition for employment (149).

Although 193 handicapped boys and girls were unemployed in January 1963, the number would have been much larger had it not been for the devoted efforts of teachers and doctors in the special schools, followed by vocational guidance and careful placement by Bureau officers. Cooperative employers and welfare organizations in Liverpool were also very helpful (149).

A 1951 Birmingham survey provided follow-up data for disabled young workers in 54 firms engaged in light industry, hiring from 20 to 10,000 employees (387). This was during a period of full employment in a large industrial city. The sample included 140 young people, half registered as disabled and the other half considered eligible for registration by their employers. Less than half had used the services of the Birmingham Juvenile Employment Bureau in finding their first jobs, and only 22% of those who went on to second jobs returned to the Bureau. Those with more serious physical disabilities, the mentally subnormal, and the epileptic tended to seek further employment only through the Bureau. Others found a second job through the advice of friends or parents, and then if this or subsequent jobs proved unsuccessful, they turned to the Bureau for help. Of the total, 25% were in clerical work, and 25% were in training for skilled mechanical jobs. Though the law requires a firm hiring 20 or more persons to include 3% from the Disabled Register, many firms were found to hire more than this quota. Only 6 out of 11 firms offering apprenticeships were willing to take disabled young people. The policy in hiring the handicapped depended on the size of the firm, the nature of the industry in which it was engaged, and the layout of the premises. Layout was important in that suitable jobs for the handicapped with leg disabilities or heart trouble might be impossible to find in old buildings with difficult stairs, modern buildings with several stories and no elevators, and factories without toilets on each working floor.

Large firms were able to offer a variety of jobs and of training, good medical, social and supervisory facilities, and were often willing to adapt plant or procedure to suit the

capabilities of the disabled. On the other hand, small businesses could only offer a restricted choice of jobs, with limited medical and social facilities, and were unable economically to make special adaptations for the disabled. . . . Light industries were better able to employ the disabled than heavy industries (387).

The most objective criterion of successful placement was continued tenure of employment; 50% were found to be still in their first jobs at the time of the survey. The most stable group was that in which parents had found work for their children within their own employer's organization, with resultant immediate parental supervision, and intercession when necessary. Nearly all the deaf and partially hearing and educationally subnormal were still in their first jobs.

In 57 out of 90 instances of job-leaving, the employee left of his own accord. In only a third of voluntary job changes was the physical disability the cause. Some of the reasons cited were unfavorable working conditions, nervous strain, excessive noise, or recurrence of illness. Discharges from the job were often due to the employee's physical incapacity for the work, emotional upsets with other workers, inability to pass physical tests, and absenteeism, although attendance and illness records were similar to those of the able-bodied except for some epileptics and asthmatics. Dismissals for such reasons were commonest in small firms with the least facility for job interchange or with limited personnel to overcome such difficulties.

Handicapped youth through inexperience take "blind alley" jobs offering no training or future prospects. They may attempt to conceal their disabilities, in order not to prejudice their chances of getting the job, with the risk of later failure, humiliation, and a sense of insecurity and stigma. It has been recommended that more of them be sent to large firms where chances of successful placement are greater. More training and apprenticeship facilities should be made available to them. They should not be placed in jobs specifically designated for the disabled such as lift and car-park attendants, which are "blind alley" jobs for young people (387).

About half of the mentally subnormal and educationally subnormal persons under the supervision of the Special Services After-Care Subcommittee of the City of Birmingham were reported as having been gainfully employed in 1960 — 57% of the men and boys, and 46% of the girls and women, with a large proportion of the females engaged in household duties (34). It was found that at age 15 or 16 the majority of the youngsters are anxious to "go to work." The introduction during 1960 of simple and suitable "outwork" (such as carding of hair curlers) at the Bell Barn Senior Girls' Center proved to be an unqualified success.

Almost all the girls and women are capable of undertaking some work and in their own eyes they have achieved the

status of workers. Their greatest satisfaction has perhaps been seeing the carded curlers on sale in shops and stores and to this has been added the satisfaction of taking home a small pay packet. It has been agreed that the profits should be distributed among the girls on the basis simply of the number of hours' work which they have done; that is, without regard to their different speeds of work (34).

Their earnings, which usually do not total more than about a pound a month, do not affect the family's entitlement to Family Allowances or National Assistance.

The experience of these cities with after-care services has demonstrated that in order to understand fully the employment prospects and problems of handicapped youth, further research is needed concerning what actually happens to them after they leave school (97). Adequate assistance to handicapped youngsters in finding and keeping employment must be based on exhaustive studies of their post-school careers, studies such as those summarized in the Liverpool after-care reports (149) and the 1960 Ministry of Labour inquiry (209). These investigations need to take into account the multiple variables affecting the work history of handicapped young people lest misleading conclusions be drawn. For example, the report by Ferguson and Kerr on handicapped young people in Glasgow indicated a superior employment record for school leavers with cardiac disease as compared with a mixed group with other forms of disability. But when the data were further analyzed, it was discovered that when cases were equated in terms of family background and social conditions, the difference was only negligible. In other words, the disadvantages of a culturally deprived early life produced differences assumed to be due to the disability itself (75).

In some instances, follow-up studies of former pupils are made by the special school itself. Examples of the employment records and adjustments of handicapped youth with various kinds of physical disability are cited in a report of a 1961 follow-up study of 20 school leavers who had left the Baginton Field School for the Physically Handicapped in 1958 at the age of 16. At the time of the survey all but one of these young people were employed. A few of these cases were described as follows:

R.E.—congenital heart disease. I.Q. 107. 2 jobs: assembly, drilling.

R seemed to have a mature attitude to life, viewing his handicap dispassionately and sensibly. Had changed jobs because his workmates, although friendly, were middle-aged. His second job paid well and he liked his colleagues but had no particular liking for his work or ambitions regarding it. Interests were fishing, country life, cinema, T.V.

and records. Member of Church Youth Group and Old Pupils' Association. Relationship with both parents good. R had a steady girl friend and aimed to get married, set up a home and buy a car. It was felt that he would achieve these aims as a normal, well-adjusted member of society.

M.H.—T.B. hip. I.Q. 127. 7 jobs: woodworker, pump attendant (2), labourer (2), meter reader, assembly.

M. although intelligent and lightly handicapped, had had the most jobs. Had secured carpentry job before leaving school but firm had gone bankrupt before he started work. Had been good in carpentry at school but after this initial set-back, being of a happy-go-lucky disposition, had given up ambitions to work with wood. Made toys for his cousins. Interests included football (although hampered by surgical boot), jazz, darts and billiards. Kept up friendships with classmates. Although M seemed to have overcome his disappointment, some after-care might have served to encourage him to retain his ambitions.

A.P.—damaged spine. I.Q. 115. 1 job: clerk with Council.

A had been paralyzed below the waist since a rugger accident. At school he had adjusted himself to his altered life, had been a successful Head Boy, popular with staff and pupils, and an inspiration to all. Before his accident sport had been his main interest. Since, he had developed powerful arm and shoulder muscles and led an active, independent life. He played basketball, table tennis, and represented England in these and swimming at the Paraplegic Olympic Games in various parts of the world, driving himself and a friend there. A quite liked his work and got on well with his colleagues. He was studying to be an accountant but had failed his exams so far. Kept up a close friendship with M and P. A had made a perfect adjustment to a handicap which, for a youth of his interests, could not have been more severe. He was resolved to study harder and the next few years would probably bring a more serious attitude to work and a full maturing.

In another follow-up survey, a study of 343 children in 30 cerebral palsy schools and units in England and Wales was begun in 1957, to extend over a period of ten years, by which time many of the youngsters will have left school or will be about to leave school. It will then be possible to review their success or failure in employment, and assess what was done for them while in school (183).

Some principal school medical officers, in their annual reports, give data concerning the careers of handicapped youngsters in the first few years after leaving school. A report from the principal school

medical officer in Hull said that 80 of the 110 children who left special schools in 1959 and 1960 were in regular employment; 6 were in irregular employment; 8 were unemployed; 8 were attending adult training centers operated by the local health authority; 4 were in approved schools (for delinquents); 2 had left the city; one was taking a course of further education and training; and one could not be traced. There apparently are sufficient statutory powers for the local authorities to provide effective after-care, though few authorities make use of these powers (183).

Although some large population centers like the cities cited have organized good programs of after-care and have made studies of the post-school careers of both handicapped and able-bodied youth, the English feel there is still need for more comprehensive and far-reaching services of this kind, even though existing services go beyond those available for youth in most U. S. communities today.

EMPLOYMENT OPPORTUNITIES RELATED TO SPECIFIC DISABILITIES

Blind

A blind youngster may leave school at age 16 if he wishes, and find suitable employment in the open labor market (295). In general there are five different agencies through which the blind school leaver can find employment. The most common procedure is for the youngster, during his last term in school, to see the placement officer employed by the Royal National Institute for the Blind who works in close cooperation with the Ministry of Labour. As a rule this placement officer calls at the school to discuss the head teacher's assessment of the child, interview the youngster himself, write out a report, and make recommendations (97).

A survey in northern England gave the following data concerning blind school leavers:

Sheltered workshop	37%
Royal Normal College	17%
Open industry (sometimes preceded by industrial training)	21%
Hethersett Centre (for assessment and training) ..	16%
Sent home as untrainable	9%

Practically all the youngsters from the Royal Normal College, as well as a few from Hethersett, are trained chiefly as stenographers and go into open industry. About 40% of the blind students receiving the equivalent of a secondary modern school preparation are able to manage in open industry in the long run. If school leavers from grammar schools and technical schools for the blind were added to these figures, the percentage would be even higher. This proportion

dates from the 1948 Disablement and Resettlement Act; before that, fewer than 10% reached open industry (97).

The rapid increase in the variety of jobs available to blind youth in ordinary industry has resulted in part from the satisfactory factory experience of the blind during World War II (218). In addition to factory work they find employment to an increasing extent as shorthand typists, telephone operators, and in executive and administrative work in commerce and industry, in central and local government service. However, many concerned with placing the blind believe that there are still far too few openings in administrative or managerial capacities.

The Worcester College for the Blind reports:

A number of blind boys who have been able to enter business, by the influence of relatives or otherwise, have been successful. Experience has shown that, for boys whose parents cannot find openings for them, the most suitable careers are to be found in the profession of Physiotherapy, the Solicitors' branch of the Legal Profession, and (if they have the vocation) the Ministry of the Church.

Old boys are University Teachers, Ministers of Religion of various denominations, Solicitors, Chartered Physiotherapists in hospitals or in private practice, Blind Welfare officials, Schoolmasters, Farmers, Home Teachers of the Blind; others are employed in Government Departments and Local Government Offices, in Engineering, Wireless Maintenance, Commerce and Business (400).

The Headmaster and the Secretary of an alumni group called the Old Boys' Union keep in touch with the boys after they leave the college.

The Chorleywood College for girls with little or no sight states that:

A great many take the secretarial or telephony training provided by the R.N.I.B. at Pembridge Place, London, and many also go to the R.N.I.B. Physiotherapy School. A few train for teaching, social work, music or law. The choice of career is dependent upon a number of factors apart from interest and ability, upon stamina, personality, independence and the use of residual vision. Other careers being followed by former pupils include domestic science, nursery nursing, home teaching of the blind, braille transcribing, and part-time lecturing (33).

The Ministry of Labour summarized in May, 1963, the following data concerning the employment outcome for the government grants made for professional training (220). Of the Grants made since

April 1, 1949 (when for the first time data for the civilian disabled were separated from those for ex-servicemen), 767 had ended by March 31, 1963, in the circumstances and with the results shown in the following table:

<i>Reason for ending of grant</i>	<i>Number of grants ended</i>			<i>In suitable employment</i>		
	<i>Blind only</i>	<i>Others</i>	<i>All</i>	<i>Blind only</i>	<i>Others</i>	<i>All</i>
Course completed						
(a) Qualification gained	131	389	520	128	298	426
(b) Qualification not gained .	3	65	68	2	33	35
Premature termination	27	152	179	2	17	19
Total	161	606	767	132	348	480

The blind have a better outcome in terms of employment percentages than the sighted disabled, though this might be due to more limited employment objectives. Of all the blind to whom grants for professional training were given, 82% eventually found employment, whereas 98% of those who gained the qualification sought were successful in finding employment. On the other hand, only 57% of the sighted disabled who received grants found employment, whereas 77% of those who gained qualification were employed as of March 31, 1963.

In proportionately fewer cases of the blind there was a premature termination of the grant as compared with the sighted disabled—17% versus 25% (220). The reasons for the premature terminations of grants were as follows:

	<i>Blind</i>	<i>Others</i>	<i>All</i>
Died	1	1
Ill health	5	46	51
To take employment	1	18	19
Examination failure	3	29	32
Inability to cope with studies ..	15	37	52
Domestic (or personal)	6	6
Financially ineligible	14	14
Misconduct	2	1	3
Unsuitable for physiotherapy ..	1	..	1
TOTAL	27	152	179

For many blind persons, sheltered employment or homework arrangements may be the only solution to their employment needs. Local authorities are empowered to maintain, or to contribute to the maintenance of, workshops and homeworkers schemes. These powers and responsibilities were continued by the National Assistance Act, 1948, but have been under the Ministry of Labour since the passage of the Disabled Persons (Employment) Act, 1958. There are 67 workshops for the blind, of which about one-third are administered directly by local authorities, and the remainder by voluntary organizations. Altogether they provide employment or training for about

4,000 blind persons, of whom about three-quarters are men. The Ministry of Labour pays the full cost of training adult blind persons in these workshops, and makes grants towards the expenses incurred by local authorities in operating them or contributing to the costs of voluntary organizations which operate them. The workshops are also inspected by this Ministry (218).

Workshops for the blind generally make baskets, brushes, and mats by hand (the traditional crafts of the blind) but some have now installed machinery. At Bristol some brushes are machine-made, and machine parts are reconditioned on a powered lathe. Soap has been made for several years at Luton, and there are two workshops at Peckham Road, London, with powered machinery, making knitting needles and molded plastics. The blind, even more than the sighted disabled, are finding their crafts displaced by machine-made mass-produced articles (286).

A report issued in November 1962 by a Minister of Labour committee on workshops for the blind, gave detailed information concerning the employment of the blind, in addition to recommendations concerning their training which may affect the education of the blind over 16 years of age (175, 217).

As of December 31, 1960, there were 97,469 registered blind in England and Wales, of whom 30,456 were in the working age range between 16 and 64. The types of employment engaged in were as follows:

<i>Type of Employment</i>	<i>Male</i>	<i>Female</i>	<i>Total</i>
Workshops for the blind	2,342	616	2,958
Homeworkers schemes	774	338	1,112
Other occupations including professions ..	5,015	1,222	6,237
Total in employment	8,131	2,176	10,307
Approximate % of those of working age in employment	50%	15%	33-1/3%

This represents an increase in the percentage of those employed since the Tomlinson Report of March 31, 1941, which indicated that only 22% of those of working age were then employed. The proportion of young people in the age range 16 to 20 inclusive is relatively small; as of December 31, 1959, there were only 142 of this age in open employment (86 men and 56 women) and 14 in workshops for the blind (7 men and 7 women). Since the number of blind children continues to diminish, an eventual decrease is expected even in this small number of employed blind young adults in the future. Only 19 employable young persons in this age range registered for the first time in England and Wales in 1960 (217).

An analysis of the trades followed by blind persons in employment and training in workshops for the blind on May 31, 1960, indicated that the largest number were engaged in basket-making, in spite of the effort to provide more opportunities for them in other types of

activity. The occupations of greatest frequency out of a total of 3,903 were as follows:

Basket making	994
Brush making	821
Bedding and upholstery	437
Machine knitting	437
Mat making	404
Chair caning and fibre furniture	163
Wirework	101
Carpentry and woodwork	80
Boot and shoe repairing	75
Light engineering and assembly	60

Baskets, brushes, mats, bedding, boot repairing, and wirework are all predominantly men's trades, though they do employ both men and women, particularly in the making of light baskets and wire-drawn brushes, and in sewing work. The trades employing mainly women are knitting and chair caning. The manufacturing processes in the workshops are becoming outdated and unprofitable, but only a few have introduced new, simpler, and more up-to-date processes (217).

Some shift in the distribution of occupations, however, is indicated by the list of positions held on June 20, 1961, by the 372 employable blind persons who registered for the first time during 1960. While 89 were craftsmen, production process workers, and laborers, 24 were in professional, technical, administrative, and executive positions, 23 in clerical and related work, and 19 in sales work (217).

Experts agree that there needs to be reappraisal of the employment possibilities of the blind. This is illustrated by the case of a blind boy in Holland, Lincolnshire, who was illiterate at age 16. After home teaching in reading and writing Braille and in arithmetic, he attended a course at Letchworth Training College and is now working as a micrometer operator in an engineering works (286).

Deaf

Although deaf school leavers, like other school leavers, are helped by youth employment officers and by head teachers to find jobs, in most areas this kind of assistance comes chiefly from trained welfare officers of the deaf. Some of them are general welfare officers in local government service who have had special training, but the greater part of the welfare work is done by the staffs of the voluntary Institutes or Societies for the Deaf, traditionally called "Missions" (49). Youth employment officers who have placed deaf school leavers in jobs do usually continue to visit them regularly during their first year or so in employment. This increases the youngster's job stability, for the officer can help to clear up any misunderstandings that arise between the deaf youth and his colleagues, and give

the youth and his employer a chance to discuss his progress and his prospects. When the placement has been done by a welfare officer, the same practice of regular visits is followed.

Since World War II, the proportion of deaf school-leavers holding skilled jobs as distinct from unskilled is believed to be higher than the national average for the population as a whole, but even so, there seems to be little doubt that many of them could hold still better jobs than they are usually given. Many potential employers are inclined to exaggerate the trouble and inconvenience arising from deaf workers' difficulties in communication. Obviously they cannot answer the telephone, but they are generally more skillful in following instructions and in assimilating work techniques than employers who have not had deaf workers before are sometimes willing to believe. There is also a persistent though unfounded fear that deaf workers will be more accident-prone because they cannot hear warnings; actually, deaf workers, like deaf car drivers, are so trained to observe visual cues as a substitute for auditory ones that their safety record is above average (49). Furthermore, the Industrial Injuries Act eased the concern many employers had about liability for the deaf under the Workmen's Compensation Acts (403).

The chief complaint is, however, not so much the lack of employment—unemployment among the deaf is only slightly above the national average—as is the quality of it. The deaf often are not given the responsibilities and the opportunities for promotion which they deserve. Since they can work at a good pay level, they are likely to stay with such jobs for lack of a chance to prove that they can do better. As indicated by a regional study of the employment of deaf school leavers (a study to be discussed later in greater detail), the range of jobs open to them has widened markedly in recent years. The trend toward automation, with a variety of operations now performed by machine rather than by hand, has benefited the deaf, since a deaf worker can tend a machine or read a dial just as well as any other worker, and perhaps even better because he is less readily distracted by the noise around him.

There is probably no occupation or profession in the country—including music and the armed forces—in which there is not at least one deaf person (49).

Although it is difficult to generalize about the employability of deaf school leavers because the category of "deaf" includes such a wide range of characteristics, it is probably true that the more hearing they have the easier it is to obtain work commensurate with their abilities. In employment the principal factor is the ability to communicate, which varies with the degree of hearing, though not entirely (97, 218). Much depends on the type and degree of the handicap, the extent to which the handicap is offset by lip-reading and the use of a hearing aid, and the age, experience, and qualifications of the

individual. In general deaf and partially hearing persons do not need to be placed in sheltered employment but can be satisfactorily placed in ordinary industry (218). Since communication problems make it very difficult for the deaf to go on with further education, they seldom undertake apprenticeships involving further education (97).

Like other handicapped persons, the deaf are sensitive about their disability, and may be suspicious and extremely "touchy" whenever it is referred to, or whenever they believe that someone else is conscious of it or is talking about it. Many deaf workers complain that their co-workers are talking about them, when this is not actually the case. The employment interview can be a nerve-wracking experience when, as is often true, the employer seems to be discriminating against them purely on the basis of their disability. For this reason the personnel interviewer needs to be warm, friendly, and cordial but at the same time matter-of-fact. The co-worker also needs to be impressed with the need of behaving toward the deaf employee, as toward any other handicapped worker, in a natural way. A sponsor or friend to whom the young worker could take his problems would be helpful, and this person in turn could if necessary discuss the young person's problems with the management (97).

The initial reluctance of an employer to hire a deaf person is often overcome by showing that deafness, unless combined with other disabilities, is unlikely to affect job efficiency. A Ministry of Labour leaflet on the employment of the deaf is used by DRO's in trying to secure the cooperation of employers. Some firms have found it best to hire deaf workers for noisy jobs such as riveting, spray painting, etc., where their deafness is actually an asset; this is also true in noisy office work such as comptometer operating, card punching, and copy typing, though this would not apply to those suffering from nerve deafness (218).

A lack of hostel facilities adapted to meet their needs may also present an obstacle. The Royal National Institute for the Deaf maintains a hostel for working deaf boys in North London, and recognizes that the next most immediate need is for a hostel for deaf working girls run along the same lines as the one for boys. The RNID expresses the view that in spite of all the discussion of "integration" with the hearing world, the profoundly deaf of all ages find greatest understanding and happiness in groups of their own kind (334).

Some interesting data on the kinds of employment entered by deaf school leavers are found in a regional study. In order to determine the form of further education most needed by the deaf as well as the extent of this need, the North Regional Association for the Deaf has undertaken a follow-up study of the employment situation of three groups of deaf school leavers from the sixteen schools for the deaf and partially deaf in the area covered by the association.

Three reports have appeared, each including those leaving these schools during a three-year period: 1950/51/52; 1953/54/55; and 1956/57/58 (290, 291, 292). As an example, the actual employment being followed at the end of 1959 is indicated in the survey for the third group. This was one of the most ambitious surveys of its kind, for the numbers included in the three groups were, respectively, 470 (268 males and 202 females); 532 (319 males and 213 females); and 587 (357 males and 230 females), giving a grand total of 1,589 (944 males and 645 females). Two classifications of deafness were used: Grade IIB (as indicated in Ministry of Education regulations), or those who are partially deaf and who have some naturally acquired speech and language; and Grade III, those who are too deaf to have learned speech or language naturally. Employment is listed for each grade separately, with totals for the two groups combined, and for each sex.

In the most recent survey, the order of frequency for types of employment for both classifications of deafness is as follows: boot and shoe repairing; general labouring; joinery and carpentry; skilled engineering trades; factory work (mostly repetitive); bakery and confectionery; pressing; French polishing; cabinet making; tailoring; painting and decorating; boot and shoe making; packing; gardening; and farm work. The remainder cover a wide variety, for the most part with only one or two in each classification following the occupation. A few occupations in this remainder are engaged in only by those with some natural speech, such as electrician, window dressing, and textile machining, and others are engaged in only by those without natural speech, such as paint spraying, mattress making, bookbinding, and lorry (truck) driver. When the two classifications are compared in terms of most frequent occupations, general labouring tops the list for Grade IIB, and boot and shoe repairing for Grade III.

For the females in the latest survey, the order of frequency for occupations is: machining; factory work (mostly repetitive); copy typing; tailoring; packing; mill work (wool); home duties; dress-making; mill work (cotton); office work (machine operatives); bakery and confectionery; and laundry work. When the two classifications of deafness are compared, machining comes first for those with some natural speech, but the factory work is first for those without naturally acquired speech.

An interesting comparison is made in this report of the main occupations in order of frequency at six different points since 1900, though only for those with some naturally acquired speech:

MALES (GRADE III)

MAIN OCCUPATIONS IN ORDER OF FREQUENCY

1901	1911	1938
Bootmaking	Bootmaking	Boot repairing
Tailoring	Tailoring	Cabinet making
Farm labouring	Farm labouring	Tailoring
Gardening	Cabinet making	General labouring
Carpentry	General labouring	Gardening
Cabinet making	Carpentry and joinery	Bakery
Painting and decorating	French polishing	Farm labouring
French polishing	Painting and decorating	French polishing
<i>Survey 1950-52</i>	<i>Survey 1953-55</i>	<i>Survey 1956-58</i>
Boot repairing	General labouring	Boot and shoe repairing
Joinery and carpentry	Boot repairing	Joinery and carpentry
General labouring	Joinery and carpentry	Skilled engineering trades
Skilled engineering trades	Skilled engineering trades	General labouring
Pressing	Factory work	Bakery and confectionery
Factory work	Tailoring	Factory work
Bakery and confectionery	Bakery and confectionery	French polishing
	Cabinet making	Pressing
	Painting and decorating	Tailoring

FEMALES (GRADE III)

MAIN OCCUPATIONS IN ORDER OF FREQUENCY

1901	1911	1938
Dressmaking	Dressmaking	Dressmaking
Domestic service	Domestic service	Domestic service
Laundry service	Laundry service	Laundry work
Tailoring	Tailoring	Tailoring
Shirt making	Cotton operative	Machining
Charing	Charing	Charing
<i>Survey 1950-52</i>	<i>Survey 1953-55</i>	<i>Survey 1956-58</i>
Machining	Machining	Machining
Factory work	Factory work	Factory work
Dressmaking	Tailoring	Copy typing
Bakery and confectionery	Mill work (wool)	Tailoring
Mill work (cotton)	Copy typing	Packing
Tailoring	Mill work (cotton)	Dressmaking
Packing	Packing	Home duties
Domestic work		

The shifts in major occupations reflect both the changing employment picture, with increasing commercial and industrial opportunities, as well as an increasing awareness of the capacities of the deaf, with resultant changes in their training as well as employment possibilities (292).

A comparison of data from the National Youth Employment Council which cover the same period as the third survey of deaf school leavers indicates that whereas 38% of all male school leavers for that period were learning a skilled craft or preparing for recognized professional qualifications, a higher percentage of deaf males (49%) fell into this category. Similarly, whereas for the country as

a whole only 8% of all female school leavers were receiving similar training, 18% of deaf females were so engaged.

Specific data were also given in the third survey as to the employment outcome for deaf young persons trained at the Manchester Trade School. Of the 27 known cases fully trained (who had three years of vocational training as a baker, joiner, tailor, shoemaker, or dressmaker) a third of them were not employed as trained. As the report comments:

It is still true that many young persons are sent for vocational training, not because they show a special aptitude for a trade, but because some extra schooling is desirable, arising in some instances from home conditions (292).

Details of the employment of 9 male and 7 female school leavers (1956-58) from the Mary Hare Grammar School for the deaf, who reside within the area of the association, indicate that of the four males of Grade III deafness, two became laboratory assistants and two entered a skilled engineering trade. Of 5 males with Grade IIB deafness, two entered clerical work, two became draughtsmen, and one a dental mechanic. Of the 3 females with Grade III deafness, one became a comptometer operator, another a tracer, and the history of the third was unknown. For the 4 females with Grade IIB deafness, the occupations were clerical work, qualified cook, and tracer, with one unknown.

Of four male school leavers, with Grade III deafness, who left the Burwood Park Technical School during this period, and who resided in the area of the Association, two entered a skilled engineering trade, one became a cable repairer, and the history of one youth was unknown (292).

Although some cases could not be traced, the number of those known to be unemployed varied little in the three periods investigated, remaining fairly low—5% in the third period, this figure being the same for the males and females. But since over half of the group unemployed had health reasons to account for this (43 out of the total of 76 unemployed of both sexes), this means that only 2% of the deaf school leavers from 1950 to 1958 inclusive were unemployed for reasons other than health. Such data bear out the generalization often made by organizations of or for the deaf that the problem faced by the deaf is not that of getting employment but of getting the kind and quality of employment they would prefer (292).

Deaf grammar-school students with good qualifications have also gone into law, teaching, the Church, commerce, the Civil Service, and local government. Dr. Pierre Gorman, librarian for the Royal National Institute for the Deaf, was a Cambridge scholar, and received his degree there.

Physically Handicapped

The cerebral palsied youth is aided in finding employment by several special services provided by the Spastics Society. Because it became apparent that finding employment for young "spastics" required a special knowledge of the labor market, a separate Careers and Employment Department was established in 1957. In the first five years of this service, over 2,000 CP's of all ages were referred to this department for advice on training and employment, and of these more than 200 were accepted for training, and a similar number placed in local work centers. Also 520 have been found positions in open employment, and there were in 1962 120 regular homeworkers (355). By the summer of 1963 it was reported that about 600 had been placed in employment since 1958, who by outside standards would be considered severely handicapped.*

By 1965, the Spastics Society (which since 1953 had grown from providing a single center to 97 schools and centers, and from 70 affiliated societies to a total of 150) had placed 1,000 cerebral palsied youngsters during the year (356).

This Employment Department acts as a supplementary service to the Youth Employment Service and the Ministry of Labour, who frequently consult the Department for a second and specialist opinion as to the suitability of cerebral palsied candidates for individual employment, and for recommendations as to which fields of employment they should try. When the placement of a youngster requires more intensive action than the local authorities can provide, the Department staff will make direct contact with employers in the home area, and make exploratory visits to commercial establishments to evaluate the requirements of a particular job in relation to the candidate's potentialities. Sometimes an employer asks the Department to be present at the initial interview of a youngster they have recommended, especially if there is speech or hearing difficulty. At times the applicant is observed in an initial trial period on the job. Contact is maintained with a new employee, especially during the first few weeks when certain problems of early job adjustment, familiar to the staff but not to the employee, may be resolved by consultation. Once satisfactory work adjustment is achieved, the staff withdraw from the situation, though indicating their willingness to be called in later for further consultation if necessary (357).

Most surveys of the number of cerebral palsied persons in open employment suggest that about 25% are in such work, but there are fairly wide regional variations which may be due either to the different degrees of handicap involved, or to differences in public readiness to accept such workers in various parts of the country. Hemiplegics are the most frequently employed, followed by the paraplegics. Quadriplegics and athetoids have the poorest chance of employment.

* Interview with Mrs. C. Clifton, Spastics Society, London, July 1963.

When low intelligence is associated with the cerebral palsy, this presents a further obstacle to employment. There is some evidence of considerable wastage during training — at least 50%. More training facilities and better vocational advice seem necessary (97).

Since the Delarue School opened, 32 students have left upon completing their education and training. Of these, 9 went into open employment, 6 went on to training establishments as employable persons, and 5 went to colleges of higher education and would be employable when their courses were completed. Thus 20, or 62%, were employed or employable and only 9 (28%) were unemployable. However, it is expected that the per cent who prove employable may decrease as the severely handicapped, whose school-leaving has been postponed, reach that point (45).

Though employers are generally sympathetic toward accepting the cerebral palsied youngster, much time must be spent in helping employers to understand what such a youngster can do, what initial allowances must be made, and how much can be expected of him. Often 20 or more firms must be canvassed before a contact is made. Help is essential in the first employment interview, for the youngster might become nervously talkative, he might "freeze" and become inarticulate, or he might be awkward and aggressive (46, 47).

The movements in manual work are more difficult and more tiring for the cerebral palsied than for the normal person. They cannot undertake heavy work or lifting. Light gardening (not digging or hoeing) and greenhouse work, as well as poultry keeping, are feasible. Work involving larger and coarser movements can be done first, leading gradually to work with finer movements. Many can fold cardboard boxes from previously stamped flat pieces, or do repetitive work using properly guarded machinery under supervision. In some cases the feet are more useful than the hands. Rug-making, weaving, and basket-making are not always easy enough, and do not give an output quickly enough to be very stimulating (1).

The factors affecting the employability of cerebral palsied youngsters as indicated in English studies are similar to those revealed in a three-year study from 1959 to 1962 financed in the U. S. by the United Cerebral Palsy Research and Education Foundation. A sample of 243 cerebral palsied persons was divided into a sheltered workshop group, employable only under these conditions, and an employable training and placement group. Reliable differences were found between these two groups in factors such as (1) manual dexterity; (2) communication; (3) intelligence; (4) mobility; (5) education; (6) appearance; (7) emotional readiness for employment; (8) parental influence; and (9) parental acceptance of and attitude toward the handicapped offspring (221).

Two of the largest groups on the Ministry of Labour register are those with cardiovascular disease (55,000) and pulmonary diseases

(102,000), together comprising about a quarter of the total of 660,000 adults on the register, although comparatively few of these are young people (301).

The youth with cardiac difficulties faces special problems. Absenteeism from school leads to neglected education, and invalidism leads to a lack of healthy play and association with peers. Employment is difficult to find because of a sub-standard education and an unsatisfactory medical history. Life insurance is refused. The patient may be rejected as a suitor for marriage because of his condition. It is particularly important that a careful and correct assessment of his condition be made, and that through cooperation among all concerned — patient, parents, doctors, teachers, education authority, youth employment officer, prospective employer, and cardiologist — a suitable choice of occupation and training plan be achieved. Local working conditions, which vary from one place to another, should be studied, and travelling facilities between the home and office or factory should be considered. Sedentary occupations are ideal for patients with some form of heart disease, but many such jobs in banks, insurance houses, and the post office are denied them on actuarial grounds, and because of difficulties over "super-annuation schemes" (pension plans). If they are accepted for employment, they are usually hired on a temporary basis and not accepted as members of the permanent staff, so that they do not qualify for the customary pension benefits. This means that they have the double disadvantage both of their disability and of the denial of retirement benefits which are the privilege of their healthy colleagues. It has been suggested that the Ministries of Health, Labor, and Pensions should collaborate to make it easier for heart patients to find suitable occupations, and should devise a pension plan for them which is comparable to that offered to healthy employees.

This would prevent the present undesirable custom of drafting these unfit patients into occupations entailing heavy manual labour, where a preliminary medical examination is not a condition for employment (72).

It is considered to be one of the ironies of industrial medicine that young people with heart conditions are often prevented by a strict medical examination from entering suitable occupations such as those in banks or insurance offices because of pension rules, though at the same time they can obtain strenuous and hazardous work in shipyards, docks, or construction work without any medical examination at all (370).

With heart patients, as with other kinds of patients, fear may linger and perhaps even increase during the recuperative period; this final stage following the completion of medical treatment must be recognized as an important period for recapturing self-confidence as a basis for resettlement in employment. Proper initial *habilitation*

of the heart patient—placing him in a suitable occupation as a school leaver—is recognized as of great importance in determining later readjustments following illness. Early detection and diagnosis, differentiating less serious from more serious symptoms, is emphasized in the program set up in Essex, as one example. The education and vocational training of the youngster are based on a careful appraisal of his symptoms, the youngster being sent usually to a regular school rather than to a special school or hospital school. The kind of work chosen for him is usually of a sedentary nature with no undue physical exertion such as lifting or carrying heavy loads. The social worker acts as coordinator of the efforts of various members of the team serving the cardiac youngster. Accurate interpretation of the symptoms of a cardiac employee differentiates hypertonia from systemic hypertension, and cardiac-like pains from cardiac infraction. Too often a diagnosis of heart trouble in an employee results in his dismissal. Difficulties of readjustment are much greater when the person enters a new occupation rather than a familiar routine. Some feel that three common practices of physicians tend to make the patient work-shy and therefore unemployable: (1) the conducting of unnecessary and elaborate tests and repeated examinations, (2) the prescribing of unwanted medicines, and (3) the prohibition of harmless pursuits (71).

Employer cooperation makes possible appropriate shifts of occupation within the business or industry itself when the employee's health condition makes this seem wise. For instance, a machine tool operator was moved to a section of the factory where much smaller parts were being made, so that he no longer had to handle heavy articles. Another man working under great pressure in the cafeteria was changed to the night shift where he had to serve only one-third the number of meals and thus had a much easier job. Other shifts have included those from truck-driver to dispatch clerk, and from bricklayer to storekeeper. Such changes are more frequent with younger men, and result in no loss in either wages or status (370).

The range of work for chest and heart patients is often limited to clerical or light factory employment because of the need to avoid too much travelling, continuous physical exertion, and exposure to the weather (301). When the chest or heart trouble develops after employment begins, the "white collar" worker is usually able to return to his previous work, but manual and transportation workers, who suffer a heavy incidence of chest trouble, face serious problems in trying to change their jobs. They often do not have the necessary skills for other kinds of jobs, or they may have difficulty adjusting to light work. There is much competition for certain forms of light work such as timekeeper, messenger, or watchman, and even if they get such a job, the earnings may be less than for their previous heavier work. Economic pressure in some instances forces a return

to unsuitable heavy work. Some employers who are aware of this problem keep lighter jobs for employees who have been with them a long time, and who face readjustments resulting from illness. In chronic cases it may not be possible to have regular employment throughout the year. The likelihood of absence because of illness, especially during severe weather conditions, makes it necessary to avoid employment which involves teamwork in which the absence of one worker at intervals would lead to a breakdown in production. It is important that the chronic bronchitic be identified early enough to permit the development of suitable skills for the light jobs which are suitable for him. The Chest and Heart Association is a voluntary organization that cooperates with industrial and resettlement services in helping chest and heart patients to find or to change to suitable jobs.

The fact that heart disease is a hidden disability often constitutes a problem for the job applicant or worker. As one writer has commented, employers will with great pride introduce a visitor to the blind telephonist or to the welder with an artificial arm, but the worker with heart disease usually has to explain his limitations time and time again, when he is threatened by changes of job, or of management, or of workmates. Also, since the heart condition of most patients deteriorates as they grow older, employment advice must take this future prognosis into account. The very diagnosis of heart trouble is anxiety-producing, and may lead both the worker and his employer to draw unwarranted conclusions about his limited employability. Whatever the diagnosis, there are economic, social, and personal worries associated with a heart condition. But the most difficult patients to rehabilitate are often those who cannot accept reassurance that their hearts are again healthy organs, because for them illness is an escape from reality; with these persons psychiatric treatment is sometimes successful (370).

Parent attitudes may also be important determiners of employability, and may need to be corrected, as in the following example:

The mother of a 14-year-old boy with rheumatic heart disease introduced him to the social worker as "Poor Billie — he is not like other boys." He was at that time working for a few hours a day as a paper boy, and was bitterly resentful of the fact that the family doctor had told him there was little hope that he would be accepted as a pilot in the R.A.F. This opinion was endorsed by the cardiologist, but both the patient and his parents were told that there was no reason why a minimal cardiac lesion should have such a maximum effect upon his life. After much discussion with the boy himself and with his parents, the gaps in his education were made good, and when he reached the required educational standard he was trained as a draughtsman. This boy's reha-

bilitation began at home, with the changed attitude of his parents. "Poor Billie" became during his training "our son William," who, they wrote, "is doing very well at the technical college." He later obtained work as a draughtsman in an aircraft factory (370).

Special problems faced by the ex-sanatorium tuberculous are: (1) the infectious nature of the illness and its consequences in fear of infection to the family, dislocation of ordinary social interests amounting in some cases to ostracism, and often a complete break with previous work contacts; (2) length of illness and need for continued medical supervision for many years; (3) the tendency, even with improved medical treatment, to relapse and show a high sickness rate when employed. Some patients can enter the hospital secure in the knowledge that their job will be waiting for them when they return, but others face a change of job. Occupational therapy and correspondence courses are helpful in these cases, along with the official rehabilitation machinery. Many areas lack part-time work of a sheltered workshop to bridge the gap between hospital and industry, and so the chest physician may have to choose for his convalescent patient between allowing him to return to his full-time job before it is certain that he is ready for it, or keeping him idle longer to make certain of physical recovery but running the risk of undermining his morale seriously in the process. Some sanatoria have rehabilitation programs of their own. Those who remain infectious have greater problems; they may find some jobs in Remploi, but these openings are limited in number (105).

Some patients are so unfortunate — because of late diagnosis or constitutional weakness — as to be left as respiratory cripples, and have no chance to come under the aegis of the Ministry of Labour schemes because they cannot do the minimum of four hours' steady work daily. If able to live at their own pace, they may be up all day and able to go about, but they must drift about at present feeling redundant and living on allowances with no outlet for their creative ability; many young patients are in this group. An occasional sheltered workshop is available for them. It is also difficult to arrange an appropriate scheme of home industry for such patients in varying states of health, though trained occupational therapists are found especially helpful (105).

While the incidence of TB is highest with men in the 35-to-45 age group, the illness tends to strike women earlier, and rather different rehabilitation problems are faced with them. The young girl with only minimal TB can on recovery go through the rehabilitation machinery in the same way as the young male patient. The Industrial Rehabilitation Units hold a certain number of places for women, and there are training courses. Most of the girls find light work fairly easily, provided they are non-infectious. For young married women,

rehabilitation of course lies within their own homes; here there is the constant difficulty that they may try to take over their home and family responsibilities too soon. Home helps are the saving factor here. Women patients in particular feel the need for convalescent homes where they can recuperate further before returning to household duties, but the homes that accept cases of pulmonary TB are few in number. Another need is for recuperative holiday homes for the chronically infectious. The single man or woman who has no home to return to often finds a job more easily than lodgings from which to do the job (105).

Many asthmatic children outgrow this condition, but there are about 10% with severe asthma who require attendance at a special school and who may need to make a careful choice of adult occupation.

For these children their future life and happiness may depend on obtaining suitable jobs of a relatively sedentary nature and sufficiently well paid to enable them to live in comfortable homes. The asthmatic boy who becomes an unskilled labourer is likely to be disabled or even dead before he is fifty, but if he is a solicitor or an accountant, this is not likely to happen.

Therefore his educational preparation is extremely important, as well as concurrent medical treatment (352).

The Haemophilia Reference Centers help hemophiliac school leavers to obtain appropriate training and jobs. Some have become engineers and foundry-men, and one became a member of a Motor Police Force. But in general less strenuous forms of employment are desirable. The professions would be desirable, but evidence supplied to the Piercy Committee in 1953 indicated the difficulties in the boy's obtaining the necessary preliminary education. Interruptions in the boy's education may prevent his completing education of a grammar-school level and going on to the University. He will be lucky to leave school at age 15 with a sound elementary-education background. Thus entry into the professions is improbable, and even the simpler kinds of clerical work may be difficult after a restricted general education. In addition, employers may be unwilling to hire a known hemophiliac, and it may be hard to keep a job because of frequent periods of absence. Therefore many young men have no alternative except self-employment. Even if they find a job, they need flats or houses with a minimum of steps, and help in getting safe transportation to and from work (73).

In the field of employment, epileptics come under the Ministry of Labour provisions under the Disabled Persons (Employment) Act, 1944. In addition to the normal guidance obtained through the usual medical channels — such as hospitals and regional medical services —

in finding employment, a supplementary report is obtained wherever possible with further information such as the frequency and nature of seizures. Where, as is usually the case, an epileptic consents to disclose his disability to prospective employers, a special approach is made by the Disablement Resettlement Officer to employers with suitable work, to determine whether they would be willing to employ an epileptic. If they are willing, the epileptic is submitted for consideration with a statement that the applicant is understood to be an epileptic. In practice, a special interview is sometimes arranged in which the DRO accompanies the applicant to introduce him to the employer (203).

Though it is recognized that a suitable and congenial occupation leads to marked improvement in the condition of an epileptic, such jobs are hard to find because of the limitations imposed by the medical report on the range of employment, and also because of the attitudes of employers and employees. Accurate medical assessment is extremely important. Some work is withheld from them completely, such as work with live machinery or on moving vehicles; work on ladders, raised platforms, or ramps; work near fires or heating or electrical apparatus. Usually work that is solitary or work with fragile objects is also avoided (218).

But the greatest difficulty encountered is the reluctance of employers to hire an epileptic. They are concerned about the temporary disorganization of work caused by a seizure, the undesirable personal characteristics that sometimes accompany epilepsy, and alleged accident proneness. Such concerns are usually found to be groundless where suitable employment is available and where there is sympathetic cooperation from employer and fellow-workers. Also occupational accidents for epileptics as for others are covered by the National Insurance (Industrial Injuries) Acts. Understanding and sympathy are especially important in the early stages of a new job when the excitement of starting a new job might precipitate seizures that do not recur when the initial adjustment is past. The Ministry of Labour is making special efforts to overcome negative employer attitudes (218). Yet these attitudes do persist to such an extent that epileptics in some cases are advised by a psychiatrist not to declare themselves to prospective employers as epileptics, and not to register themselves as such, since the condition is now so well controlled by modern drugs in most instances (244).

Herford found some cases of mild epilepsy and petit mal among the young workers he examined as an Appointed Factory Doctor. They presented some difficulties in placing, and much depended on the sympathetic cooperation of fellow workers and staff (103).

When attacks start after a child leaves school it is not always easy to obtain adequate information, and it is not

surprising if the family are tempted to conceal the facts (47).

Sheltered employment is sometimes the best solution for the person with epilepsy. Nearly 500 epileptics are currently working in the government Remploi factories which provide sheltered employment under conditions simulating those of open industry. Here they are not segregated from other employees, and it is found that their seizures cause little disturbance. Sheltered employment is also provided by some voluntary groups in workshops for the more severely disabled (218). Workers with other handicaps are said to be more understanding and tolerant of epileptics than the able-bodied are (286).

The better educated epileptic patient often has special difficulties in getting appropriate employment (160). In industrial and professional relationships prestige and reliability count for a great deal, while safety is the main consideration with the manual worker. For example, gardening is considered a good occupation for epileptics, because if they fall during a seizure they are less likely to hurt themselves than if they were doing indoor work. The review of the employment records of 21 epileptics accepted for training at the Portland College for Training of the Disabled between 1953 and 1959 indicates that 12 were trained as gardeners and 9 in clerical work (300). So not infrequently, when the intelligent person is diagnosed as epileptic, a serious drop in financial and social status has to be accepted (160).

Hostel accommodation plus continuous medical supervision aid the epileptic in adjusting to the normal world of work and in achieving more complete independence. At St. David's Hospital the patient for the first few months is permitted while employed to live in a special block within the hospital precincts, during which time he contributes toward the cost of his maintenance, but by saving part of his earnings he is able to leave the hospital with a small bank balance. Finding suitable living accommodations is sometimes a serious problem for an epileptic just discharged from a colony or hospital.

An unhappy experience of being given notice to leave lodgings because of social difficulties might make all the difference between a successful re-adjustment and relapse.

In general, suitable quarters for employed epileptics are very limited (203).

Young people may become handicapped for the first time as a result of accidents in the job situation itself. The number of injuries to young people in industrial accidents is considered to be one of industry's most pressing problems in England. It is reported that from 1959 to 1963 the number of reportable accidents involving

youth under 18 years of age increased by over 28%. A related problem is that if a young worker develops poor working habits, they may stay with him throughout his working life, and thus constitute a continuing potential menace to himself and his co-workers (402).

The 1963 annual report of the Chief Inspector of Factories indicates that the total number of industrial accidents is increasing steadily, even though the number of fatal accidents is decreasing slightly. In 1963 there were 204,269 accidents reported to the Inspectorate, which represented 7.4% more than the total in 1962. Of these, there were 10,035 accidents to boys under 18 in 1963, with 18 fatalities, and 3,430 accidents to girls under 18, with only one fatality. The highest percentage of total accidents occurred in building operations. Falls of persons continues to be the most frequent cause of accidents, and the bodily injuries sustained in accidents, whether in factories or construction work, are most frequently to the hands, feet, and trunk in that order. The report cites specific cases of accidents to young persons, emphasizing their need for adequate safety training, supervision, and good leadership from older workers.

Teenagers also rank high in non-industrial accidents. Motorcycle accidents, which now show an alarming increase among U. S. adolescents, have been a cause of concern in England for many years.

Job study is needed to discover new devices for aiding the physically handicapped youngsters to cope with work situations, and for obtaining new opportunities for them in open or sheltered employment. Employers themselves could make useful suggestions. The employment problems of youngsters with physical disabilities can be solved if the results of research and experience are shared by the various agencies concerned with their education, welfare, training, and employment (46, 47). The most difficult group to provide for are often the highly intelligent youngsters with serious physical limitations. Though work may be found for them in which they can use their intelligence, care must be taken to avoid their expending considerable time and effort on a difficult and lengthy course of study which their physical disabilities will prevent them from using later on. Multiple disabilities present special problems, especially when the hands are involved (80).

Continuous research concerning new avenues of employment for the handicapped has led to the discovery and development of a greater variety of work possibilities. For example, an ingenious employment scheme for the physically handicapped, undertaken by the British Council for Rehabilitation of the Disabled at the request of the Ministry of Public Buildings and Works, is the maintenance of a summer chair service in the Royal Parks of London, where 20,000 chairs are used at 6d. per four-hour session, three sessions a day, seven days a week, covering the daylight hours when the parks are open. The disabled can serve not only as uniformed attendants to

collect fees, but also as workers stripping and cleaning the old chairs and assembling new ones in a workshop during the winter (9). Job study means also an attempt to recognize the special problems which certain occupations present to handicapped youngsters, and to help them to meet these problems.

Agricultural work for the handicapped youth involves a major difficulty of getting regular treatment, when this is necessary for his condition. He is often some distance from a treatment center, with poor bus connections (74). Also the work may be too difficult, too strenuous for him, as there is no really light work on a farm. Working in the cold and wet, poor leg circulation resulting from long hours of work on a tractor, inadequate protection from clothing—all these could present problems. Protective canopies on tractors, and the use of impermeable, relatively waterproof warm clothing such as was experimented with during the Korean war, would help. In some instances, the handicap does not exist during adolescence and early adulthood, but the type of agricultural work performed, such as the constant lifting of heavy loads, may take their toll in middle life when severe arthritis develops. Some efforts are being made to retrain these persons for such activities as egg production, flower growing, and poultry packing. Fortunately the mechanization of some farming jobs has tended to reduce the handicap-producing strains of early agricultural activity.

A young person who is physically handicapped may be able to perform a useful task by expending much more energy and taking more time than the normal person, but there is usually no provision for adjusting pay rates to the slow worker. Many of such workers, when reaching the age of 21 and the level of adult pay rates, have had to leave their jobs; there is no middle course between normal employment for normal pay, and living on National Assistance with earnings over £1 a week deducted in full. According to one writer, cerebral palsied persons usually have an output of only 70% to 80% that of normal workers (47), but Dr. Brewster Miller of United Cerebral Palsy in the U. S. maintains that even these figures are too optimistic, for experience with cerebral palsied workers in the United States would indicate a figure of only 30% to 40% work efficiency.

Suitable housing and transportation are also important determinants of the employability of handicapped youth. Since the typical hostel is at times too large for some physically handicapped young persons to adjust to, efforts are being made to keep housing accommodations as small as is feasible.

Parental failure to encourage a youth's physical and social independence may prevent or at least delay the achievement of a more adult role, especially a wage-earning one. One cerebral palsied young man in his late teens, whose parents had been afraid to let him go out alone in his self-propelled chair, connived with a friend who

agreed to take him out in his chair and then leave him to return home alone. His triumphant return an hour later finally convinced his parents that he should be permitted more independent activity. After acquiring an electric tricycle he delivered newspapers, until the local housewives themselves encouraged him to start a mobile shop selling such things as soap powders door to door. There are now few people in his district who do not know the travelling salesman who calls regularly at the gate with a honk of his horn and a broad smile on his face.

Strength of determination in the young person himself, as in the case of this young man, may enable the individual to overcome employment obstacles. One young woman from the Pond's Home for the cerebral palsied wanted to try doing daily domestic work in the village, but though her standard of work was high, this was offset by the fact that she left a trail of saliva around the furniture and rooms where she cleaned. When this was brought to her attention, and she seemed to realize for the first time how other people reacted to her habit of a lifetime, she was able through sheer will-power to learn to swallow saliva and thus to overcome her difficulty (18).

Educationally Subnormal

ESN youth are found to have greater employment problems if their mental handicap is combined with emotional instability or a physical handicap such as paralysis or epilepsy (47). Those referred to the Ministry of Labour who are found hard to place have characteristics such as poor educational attainments, poor emotional control, lack of vocational training, lack of general knowledge, resentment against authority, and poor work habits, though research over the last decade has indicated that many of these characteristics are modifiable or reversible (97).

The Cheshire Education Committee has found some encouraging evidence of improved employment prospects for the "dull" (ESN) school leaver with an IQ between 55 and 85. Although some jobs previously thought suitable to them have declined in demand, such as domestic service, or have increased in responsibility, as agriculture, the increasing breakdown of industrial jobs into routine processes has increased the scope of employment for the less able (31). The list of occupations undertaken by dull school leavers (boys) in that area follows.

APPRENTICESHIPS

Plater
Plumber
Bricklayer
Joiner

Electrician
Cooper
Slater
Flagger

Fitter
Slaughterer

FACTORY

Assembly	Packing	Wire mat making
Crate making	Scrap cutting	Tanning
Box making	Screen laying	Moulding
Map making	Weaving	Casting
Electroplating	Shoe pattern cutting	Textile finishing
Battery filling	Mineral water bottling	Mail making
Glove making	Textile ringroom worker	General worker
Clog iron making	Cable making	

DISTRIBUTION

Bread, milk, coal, grocery and butchery delivery	Warehouse assistant	Coal bagging
Dairy assistant	Butcher's assistant	Van boy

OTHERS

Brick making	Deck and cabin boys (canal transport)	Kitchenhand
Creosoting	Timber yard assistant	Window cleaning
Asphalt and pavement laying	Builder's labourer	Poster writing
Refuse collecting	Signal box boy	Baths attendant
Shoe repairing	Market gardening	Potato peeling (chips)
Farming	Modbile gardening	Plant pot fettling
Parks assistant	(grounds) assistant— turf cutting and loading	Poultry

A similar list for girls is somewhat less diversified:

CATERING AND DOMESTIC

Apprentice confectioner	Kitchen hand	Bakehouse assistant
Cake and biscuit making	Pie packing	Waitress
Cafe assistant	Domestic help	

TEXTILES AND CLOTHING

Machinist	Silk worker	Trimming making
Packer	Weaver	Knitter

FACTORY

Putting salt into potato crisps	Box making	Carton gumming
Sack repairing	Fertiliser making	Packing
Brush making	Coil winder	Umbrella making
Electroplating	General factory work	Shoe machinist
Artificial teeth making	Book binding	Assembly
	Tobacco stripper	Stationery worker

OTHERS

Shop work—sales, warehouse, packing	Office machine operator	Check sorting
Laundry work—sorting, pressing	Bread and milk delivery	Apprentice hairdresser
Copy typist	Farming and market gardening	Junior clerk

The Cheshire Education Authority learned from discussions with Ministry of Labour staff members that in general it is more difficult to place educationally subnormal youngsters under 18 than ESN adults over 18.

As other studies have indicated, factors which prevent the dull youngster from holding a job are: lack of punctuality; absenteeism; failure to adjust to fellow employees or employer; inability to take responsibility; unreliability; personality defects due to emotional instability; lack of knowledge or skill. On the other hand, characteristics which enable the dull youth to succeed are: character and personality; ability to get along with his fellows; attention to detail and standards of performance; regard for rules and regulations; general emotional control; and ability to learn from experience (31).

At present about 80% of the ESN school leavers are placed in unskilled jobs, whereas the remaining 20% go to sheltered workshops. For most of the ESN school leavers in urban areas, factory work proves most suitable because of several factors: (1) the work is repetitive and therefore minimizes learning handicaps; (2) wages are good; (3) supervision is good; (4) there is companionship; and (5) there are opportunities for different kinds of unskilled work and for promotion to semi-skilled work. For women routine domestic work in hospitals or canteens is also appropriate (97).

Placing the ESN youngster in employment is only part of the problem. Since many of them have no homes or have extremely adverse ones, they need the background of stability provided by small hostels or adequate foster homes. Since relatively few of the latter can be found, there is an urgent need for hostels. Some small hostels were established as long ago as 1892 to take feeble-minded older children and adolescents out of the workhouses with the intention of training them—boys chiefly for work on the land and girls for domestic service—and trying to establish at least some of them as independent citizens (240). About one-sixteenth of ESN school leavers have need of hostel service, which provides an estimate of about 12 places per 10,000 school children. On this basis it appeared that for the whole of Lancashire County as many as 400 hostel places might be needed (240).

Hostels are also needed for the more severely retarded returning to the community from institutions. Hostels housing 20 to 30 young adults are sometimes provided, staffed by a married couple acting as house parents, and (in the case of boys) by a male nurse who acts as employment officer, social worker, and supervisor. The young men are provided with all types of work by the town councils, such as garbage collectors, sewage workers, and domestic workers. Hostel accommodations will undoubtedly be needed more and more as the number of the severely subnormal found to be capable of open employment increases.

Mentally Subnormal

Even the more severely retarded (trainable mentally retarded) called mentally subnormal or severely subnormal face improved employment prospects in England today.

It is probable that under conditions of full employment at least as many as 20 per cent of the adult defectives formerly classified as imbeciles may be capable of securing and retaining employment in the open community (166).

A recent report concerning the record of 60 subnormal people of both sexes, who worked side by side with normal employees in a Middlesex factory, indicated that their accident rate was considerably lower than that of the other employees, as was the rejection rate for their finished articles, perhaps because the task in hand demanded all their concentration.

Young people so placed were very proud of the position they had reached and immensely stimulated, so that at times the daily output of some individuals had been so high as to threaten the negotiated wage rate for a particular job (121).

In the past the hospital training of the subnormal patient was not always closely related to the kind of work available to him on discharge. Farm labor and making of shoes by hand are less suitable in an increasingly mechanized age than the performance of routine factory operations. Many subnormal hospital patients go out daily to paid employment as domestic workers in hostels, hospitals, and private homes, or as factory or farm workers. In some areas these workers live in a hostel supervised by a hostel warden rather than in a hospital. Here they pay for board and lodging, buy their own clothes, and arrange for their own vacation activities. Others under guardianship hold resident posts or live with friends and travel daily to work. Social workers from the hospital or from the local health authority visit them regularly and help them to maintain their stability and develop self-reliance. The local health authority is responsible for those living in the community under guardianship, and gives advice and help to the person concerned or to his family (218).

Research indicates that most able-bodied persons who are subnormal mentally (below the ESN classification) are capable of productive as opposed to occupational work (97). The limits of learning skills are found to be less rigid than formerly assumed, even in these individuals, for 10% of the mentally subnormal once classified as imbecile find some form of employment. Experimental studies have demonstrated how severely retarded children can be taught to perform industrial operations when these are broken down into simpler separate operations (67).

Increasing numbers of mentally subnormal persons are finding

employment in the open labor market. The Disablement Resettlement Service of the Ministry of Labour places more mentally handicapped persons each year. In 1961 this service placed about 500 mentally subnormal persons in employment, and a follow-up inquiry in 1962 revealed that two-thirds of them were still in satisfactory employment (268). The Birmingham Education Authorities produced data in 1956 showing that at that time 20% of their "imbecile" children eventually found gainful employment. Another report on patients from the Monyhull Hospital working in open industry indicated that 29% of those working in ordinary working conditions were labeled "imbeciles," and were earning regular wages (91). In one study of 221 patients discharged from a hospital for the mentally subnormal, it was found that 78% were employed after an average period of five years after discharge: 72% of the dull normal (70-plus IQ); 79% of the feeble-minded (50 to 79 IQ); and 75% of the imbeciles (35 to 49 IQ).

These figures support the clinical experience that a low IQ complicates the issues but does not decide them.

Surveys of employer opinions about the work of subnormal employees agree that in unskilled work the failure rate is no greater, and perhaps even smaller, than that of ordinary workers (91).

The following is an example of a severely subnormal youth, long institutionalized, who was enabled to make an effective adjustment to a normal work environment (88):

Freddie, an imbecile youth with an IQ 33 had always been in institutions. He was a good, reliable worker, but simple, facile, childish in judgment and over-dependent. The work he was able to do in hospital—floor-sweeping, making tea, tidying up—could also have been done outside in a factory, but for the obvious difficulties of travel, adjustment to a new environment, new people and the apprehension one has naturally when exposing such a simpleton to the dangers of a busy city. Nevertheless he was found a factory job, and careful training began. He was taught how to use public transport though it involved changing buses. He could have done it in different ways, but he was instructed to use only one particular service, though this entailed waiting and therefore earlier departure to be in time. He also knew that he had to enter the factory by a particular door, painted green, and where to collect his cleaning materials and where to start work. He was a tremendous success at the factory and was a great relief to the manager, who had had a succession of most unsatisfactory cleaners with, presumably, much higher intelligence. Today, five years after his dis-

charge, Freddie is still in remunerative employment, earning between six and seven pounds and living at home.

Freddie had been trained to move in a particular groove and as long as no obstacle occurred, he was, and still is, quite a success in his limited sphere. If the particular bus service he used had failed to function on a particular day, Freddie would of course have waited at the bus stop all day. If the door he recognized as his factory gate had been painted from the familiar green to an unaccustomed blue, Freddie would probably have remained in the street and not turned up for work. Contingencies like these are the exception and not the rule, and it is better to plan in such a limited way which has some hope of success, than to omit limited training because it cannot cope with the immense number of unforeseeable occurrences which might arise at any moment.

Education for the young adult must therefore give up the pretence of being another, simpler form of the usual educational curriculum, and it must also give up aping the formal school programme designed for normal children by cutting it down and watering it down to the Mental Age level of the young adult. The academic work, the three R's, reading, writing, and arithmetic, must serve directly the overall aim: social education.

Maladjusted

Although there is considerable information about emotionally disturbed children who receive help through child guidance centers, there is relatively little information about the adult adjustments and employment records of maladjusted school leavers, that is, youth with emotional problems serious enough to necessitate their receiving help. Since special schools for the maladjusted have existed in England for only a little over a decade, there has not yet been enough time to accumulate data from long-term follow-up of school leavers (97). The problems of adult adjustment for the maladjusted school leaver may be compounded by returning to a home which has contributed to his emotional difficulties in the first place. For him a hostel, as the point from which to seek employment, is desirable. In some ways it may be more difficult for him to find employment than for the physically handicapped or those with limited intelligence, for maladjustment includes more unknown factors than the other conditions. He needs continuing emotional support, preferably from one person he has learned to trust, and whose advice he is willing to seek and accept. If he has been taken into care, this need is met through the continuing supervision of a welfare officer until

he is 18. Or a youngster who has appeared in court toward the end of his school career may still be under the supervision of a probation officer after he leaves school. If a hostel is staffed with understanding people, one of these might become a personal friend and advisor. There should be a youth employment officer with special responsibilities for handicapped youngsters including the maladjusted.

The employment record of the youngster classified as maladjusted may be an index of the success of the treatment he has received in a child guidance clinic and possibly the special education he has obtained in a residential school. In London 70% of the school leavers classified as maladjusted are considered to be settled in employment. Where home conditions are unfavorable, these young persons are placed in the care of children's officers who work with youth employment officers in finding employment for them (47).

The National Union of Teachers maintains that the need for after-care is especially urgent for maladjusted school leavers.

Completely rejected and having no home anchorage, they have quite literally nowhere to go (274).

They are particularly in need of hostels with a well trained staff, while working or attempting to find work, in order to maintain their precarious emotional balance.

Some have found continuing protection and security only when they have committed an offense, or their families have suffered some additional calamity (274).

While the education authority has no power to organize an after-care service for the school leaver, the health department does have this power, and should make full use of it. This same kind of after-care, with special hostels adequately staffed, has also been recommended recently by a government Advisory Council on the treatment of offenders for the effective resettlement of young offenders into the community. This would mean the acceptance of a disciplined life, including wherever possible a requirement that the hostel resident earn his own living (109).

The Mental After Care Association has warned that the hostels set up in recent years by local authorities for young former mental patients should not provide solely for short-term cases of young people in full employment. Some authorities have even stipulated a maximum permissible length of stay, after which the patient must leave and look after himself elsewhere. But as the Association points out, it is the "long stayers" who provide *esprit de corps* and stability in such a setting. Also the lack of trained and experienced staff members may lead to unsuccessful hostel ventures. In such instances it often proves preferable to subsidize a group like the Mental After Care Association to provide residential accommodation for mental after-care (162).

Although the programs for the mentally ill undoubtedly serve more adults than young persons, the latter as school leavers are served by agencies which either give treatment to emotionally disturbed employees or obtain work for those who are maladjusted prior to employment. The emotionally disturbed youngster can be treated in child guidance centers while he is attending school, but once he leaves school he must avail himself of services provided for emotionally troubled adults.

An important unit for the treatment of neurosis is found at Roffey Park, near Horsham, which was started in 1944 to deal with patients who, though employed, showed signs of maladjustment. In cases where there are problems of employment, it is now usual for the Disablement Resettlement Officer to visit the hospital and establish a close liaison with the hospital staff when making plans for a particular patient. Hospital patients suffering from mental illness are, like other hospital patients, eligible for registration as disabled persons if they are employable (218).

Persons who have difficulty in finding employment through employment exchanges can be referred by the Disabled Resettlement Officer to psychiatric out-patient clinics when there is evidence of psychiatric complications. Those who need more intensive investigation and assessment can obtain them in a place like Henderson Hospital, established to study neurotics with special difficulties. Treatment here includes special group techniques, cooperation with the Government Training Center at Waddon, and testing in real-life work situations provided by local employers cooperating with this program. Results have been reported as most encouraging (218).

The possibilities of employment for psychiatric out-patients are improved when there is opportunity for evening consultations, as afternoon consultations would disrupt their work and create resentment in their employers. Some mental-health workers feel that such consultations should not occur in the mental hospital but should be provided in clinics in population centers where people can get to them more readily (68).

An interesting experiment in the rehabilitation of long-stay and long-unemployed mental patients, with a gradual transition to employment, is provided by the city of Bristol. In the first stage, the patient works in the industrial department of Glenside Hospital. In the second stage, which is called the Industrial Therapy Organization, out-patient experience in actual work situations is provided while the individual continues to live at the hospital. In the third stage, there may be further training in open industry and open industrial employment (117).

By March 1962, after two years' operation, 55 patients (23%) had become wage earners, the majority (91%) within their first year in ITO. The larger proportion of patients coming to ITO were at first

referred from Glenside Hospital, but this trend is being reversed by increased referrals from other psychiatric sources and from non-medical sources. Subnormal and epileptic patients were included; subnormal patients presented no difficulties, but epileptics occasionally caused a disturbance. Long-hospitalized, long-unemployed paranoid schizophrenic patients over 40 appeared to have the best prognosis, whereas younger patients with short unemployment records and less than one year in the hospital fared worse in an organization such as the ITO (117).

Results in general were so favorable that it was felt the Industrial Therapy Organization could well replace some more conventional and traditional ways of serving the handicapped. The Car Wash unit was especially successful in 1962-63. A team of men laid a concrete floor in a factory. Another team, for whom a four-week stay in a factory was planned, actually stayed for 16 weeks, and received a very favorable report from the company. One team of 12 female patients had been employed continuously for 18 months in the Hygienic Straw Company. The girls from the sheltered workshop in the hospital were among the poorest operators there, but when working as part of a factory team their performance improved remarkably. This would suggest that sheltered workshops as envisaged by the Ministry of Labour are a poor substitute for open employment. The ITO therefore recommended its own form of "sheltered placement in industry" to the Ministry of Labour (117). Such a plan does not require a special factory, with low and uneconomical production and a slow tempo. The sheltered workshop usually has difficulties in keeping a constant supply of sufficiently remunerative work flowing through such a factory, and providing sufficient financial incentive. The Bristol report maintains that at Remploy rates of pay for a 40-hour week, many people are better off when not working.

The general suggestions for improving the employment prospects of handicapped youth can be summarized as follows:

(1) Better coordination of existing services that span the transition from school to job, perhaps through a central regulating agency.

(2) Provision of adequate follow-up of handicapped youth after placement in order to ascertain the special adjustment problems faced, to give continuing assistance, and to improve present services.

(3) Expansion of housing facilities for employed handicapped youth to make possible a freer choice of type of work and also a geographically wider range of selection of job opportunities. It is assumed here that special equipment extending the youth's physical functions is made available to him.

(4) A continuing study of the general employment situation in terms of special adjustments required, changes in types of work

available, and job demands determining suitability for the handicapped. This assumes (a) that such information is made readily available to key personnel such as the youth employment officer and the Disablement Resettlement Officer; (b) that job analysis indicates the basic requirements of existing or changing types of employment; (c) that appropriate changes occur in the training available to handicapped youth; and (d) that realistic industrial regulations, pension programs, etc., are based on such information.

(5) Continuous effort to educate the public in general, and potential employers in particular, as to the desirability and feasibility of employing handicapped persons. This emphasis is of course part of the broader recognition of the needs and rights of the handicapped as human beings, as evidenced in willingness to experiment with placement of the handicapped in a given job situation and to make reasonable adaptations for them in their work environment.

On the whole, the evidence indicates that employment prospects are improving for all groups of handicapped persons, and that the school leaver with some kind of disabling condition faces brighter prospects for the future than ever before.

SHELTERED EMPLOYMENT

Sheltered employment of the more severely disabled, who cannot be placed in open employment, is provided by (1) a non-profit distributing company specially set up by the Ministry of Labour for this purpose — Remploy; (2) voluntary associations which maintain approved workshops or other facilities; and (3) local authorities. Sheltered employment may be made available either in workshops or in programs of homework.

Remploy

The most ambitious sheltered-workshop undertaking is that of Remploy, which is said to be unique. Remploy was established in 1945 by the Ministry of Labour under the Disabled Persons (Employment Act), 1944, as a special public company to provide sheltered employment for the severely disabled. The company operates as a commercial concern engaged in ordinary production and sales that include book repairing and binding, cardboard box making, surgical appliances and boots, leather and travel goods, protective clothing, textile sewing, light engineering, packing cases, upholstery and furniture making, mattress making, commercial knitwear, and brushmaking (10). There are at present 89 factories employing a total of 6,870 severely disabled workers. The Ministry of Labour is planning a substantial expansion of Remploy activities in order to increase sales and production and thus to make it possible to increase the number of disabled employees to 7,650 in 1968-69 (294).

Deficits are met from public funds. Remploy does operate at a

loss, since the factories are located with the purpose of serving as many disabled persons as possible and permitting them to live at home while employed. The Remploy production work-force includes only 10% able-bodied persons, recruited from ordinary industry for the more strenuous or more specialized jobs. With 90% of the employees severely handicapped, the lower production and consequent deficits are justified on the grounds that the subsidies are much less than the cost of the social services that would otherwise have to be provided to maintain dependent and unhappy persons. It is estimated that while it costs about £7,000 to bring a severely disabled person to the point of being self-supporting, it costs £17,000 or more to keep him for a lifetime in idleness (95).

Dr. W. R. Usdane, who studied Remploy under a Fulbright Senior Research Fellowship for the academic year 1962-63, has contrasted the employment of about 6,000 severely disabled persons in England in government-subsidized factories, of whom 200 a year leave on their own volition for regular employment,* with the situation in the U. S., where there are over 700 sheltered workshops, all run by voluntary agencies, and no government-subsidized venture like Remploy. The American voluntary workshops are used primarily for those temporarily unable to enter regular employment, and resemble more the English Industrial Rehabilitation Units of the Ministry of Labour, rather than Remploy factories. Sheltered workshops in America which provide terminal employment resemble the Occupational Centers (training centers) in England which are administered by local authorities with some assistance from the Ministry of Labour (382).

Jobs in Remploy are filled by the local employment exchanges. Young people under 18 who are so severely disabled that they are unlikely to obtain or retain jobs in the regular labor market are referred by the youth employment officer to the Disabled Resettlement Officer, who places them with Remploy when possible. Remploy units operate as much as possible like regular factories. There is no formal program of evaluation, and beginning workers are trained on the job. There may be assessment and a case study at the time of consideration for employment, or at an Industrial Rehabilitation Unit. New recruits get an assessment and "toning-up" course before entering the factories when geographic location permits (316).

Special attention is given the recruit in terms of job selection, medical services, and recreation. During the initial training period, efforts are made to find out the work most suitable for the worker and to adapt machinery and speed of work to meet individual needs. Wages are based on a standard minimum rate for each trade arrived at through negotiation with the appropriate trade union. All em-

* Miss M. A. Straton of the Ministry of Labour reported in an interview in July 1963 that while as many as 200 may leave for open employment in a given year, as few as 2 or 3 a month may leave at times when employment opportunities are limited.

ployees have the chance to earn more than the minimum. The principal medical officer at Remploy's London headquarters advises on general medical questions and reviews individual cases.

Each factory employs a local doctor who advises the works manager, makes frequent visits, and gives each employee a medical examination every six months. Every factory has canteen facilities and many have social clubs. A quarterly house organ, the *Remploy News*, keeps employees informed about activities in the organization as a whole.

Remploy also operates a homework program in which supervisors instruct homebound employees, distribute materials, collect the products, and make payments for work completed. Homeworkers must be able to do productive work, since this program is not a form of occupational or recreational therapy (316).

Remploy has been criticized for not serving handicapped young people adequately. It has been said that the nature of Remploy organization and the kinds of products made at individual factories too severely limit the selection of handicapped persons, and that vacancies are only occasionally made available to young persons. Since the primary function of Remploy is to provide work for severely disabled persons unable to compete in the open labor market, youth employment officers are reluctant to refer young people unless it is clear that they fit into this category. Their youth and lack of experience make such judgments very difficult (10). The proportion of young persons employed by Remploy thus remains low. Of the 6,400 employees in Remploy three years ago, only 76 were under the age of 18, and 269 under 21. The proportion of boys to girls tends to remain constant, with about twice the number of the former getting Remploy jobs.

If the young person is employed, his chances of making a successful adjustment are excellent. Out of 124 cases recently reviewed, only 10 had been found to be unsuitable after a trial period; 107 were still employed by the company and 95 of these were regarded as satisfactory, with 12 others showing possibilities of improvement. In view of this record it has been recommended that this form of sheltered employment be made available to more young handicapped persons. The prospect is that some of them might later graduate to open employment (10).

An example of the way in which a severely handicapped youngster can be aided by Remploy is that of Johnny, a spastic diplegia from birth, who learned to walk with great difficulty, and also suffered from defective hearing and speech. During his irregular school attendance he was irritable and bad-tempered, reacted negatively to discipline, and concentrated poorly, probably because of a deep sense of frustration resulting from his physical limitations. When the youth employment officer recommended him to the Remploy area

liaison officer for consideration, Johnny was a sorry sight, with poor gait and speech, head lolling to one side, and little hand coordination. However, there were indications of a fair level of intelligence. With the help of the factory manager, the officer designed a nest of boxes which were left for Johnny to work with for a week. When he reappeared at the factory a week later and showed that he could handle the boxes, he was given a three-months' trial that proved successful. He was not easy to handle at first, and his first year's progress was slow, but he had an insatiable appetite for work, he was happy once he was working with other people, and he became a kind of pet of the rest of the factory. Eventually he was able to operate several different kinds of machines, and in addition he engaged in normal activities such as getting out on his own, going to football matches, and stopping at pubs for a pint of beer.

Remploy faces two major dilemmas: (1) The company has grown into big business, and yet the legislation indicates that it is a social service. But if Remploy should provide more transitional avenues to outside or regular employment, it could hardly operate its extensive sales, transport, and warehousing organization with a less stable work force (2). There is question as to whether Remploy can proclaim itself part of the Ministry of Labour rehabilitation program for the disabled and still maintain the image of a commercial organization. Will executive sales staffs and representatives join Remploy from outside industry if they feel that Remploy products are not up to normal commercial standards? Though in the early days there was some question about the quality of Remploy products, the company has now established an excellent reputation. As Remploy has grown it has tended to become more bureaucratic with emphasis on achievement as a commercial concern rather than on the vocational rehabilitation of the severely disabled into open or regular employment (383).

Voluntary Sheltered Workshops

Employment opportunities on the sheltered workshop level are needed in communities too small to provide the manpower for programs on the Remploy model. Voluntary organizations attempt to fill this gap with sheltered workshops of their own. These workshops are struggling to survive, and some have had to close down. Wages and the cost of materials are constantly rising. Changes in public taste, which determines the demand for particular products, affect the sheltered workshop as well as regular industry. Machines are replacing hand labor in many traditional crafts. Light basketry is giving way to plastics, many types of brush can be made by machinery much more cheaply than by hand, and fine needlework is less appreciated now than formerly. One answer is for sheltered workshops to introduce more power machinery; for example, one workshop for the blind makes molded plastics with such equipment. How-

ever, modern machines are expensive, and the Ministry of Health can only justify capital advances when it seems evident that this will make the workshop more nearly self-supporting. In setting up a sheltered workshop, it is now recommended that the making of brushes, baskets, and mats by hand be avoided; light basketry is found to be a dying trade except in areas where early vegetables are grown, and the blind can make all the heavy baskets needed (286).

The sheltered workshop is supposed to serve the dual purpose of providing permanent employment for those unable to work in normal industry, and acting as a half-way house for those who will (or may) become fit to take and keep an ordinary job. Since passing on the more highly skilled workers to open industry can result in a drop in production, some workshops make it a point to hire a certain number of able-bodied workers (as in Remploi) who can keep production moving. An effort is made to maintain a balance between training and employment where it is clear that those trained are unlikely to pass on into open industry (286).

The workshops for the blind have the longest history in the field of sheltered employment. In the late eighteenth and early nineteenth centuries schools established for the blind by voluntary organizations included the teaching of some industrial handicrafts, but few blind persons so trained were able to support themselves without help. The Scottish practice of providing a workshop in connection with a school to employ former pupils was eventually adopted in England, and some of the workshops established are still in existence today. As the numbers of blind workers increased, a trade union was formed in 1893, called the National League of the Blind, which campaigned vigorously for state aid and improvements in workshop conditions, as a result of which a government committee in 1914 made a comprehensive study of conditions in the workshops. By 1939 there were over 60 workshops in Great Britain, with about 4,500 blind workers. The geographic distribution varied considerably, with some areas stressing homework programs to a greater extent. In the period between the two World Wars some progress was made in opening professional and commercial work to the blind, but virtually no industrial work was available except in the workshops and in homework programs. The training of young persons and adults in these skilled trades remained the responsibility of the local authorities, and was provided either in special training institutions or in the workshops themselves, this training usually lasting four or five years.

The Tomlinson Committee Report in 1943 noted that blind persons had at last been able, under war-time conditions, to secure work in ordinary industry in processes such as packing and testing of precision instruments. But the committee believed that most blind persons would continue to need the sheltered workshop provisions of local authorities.

Following the passage of the Disabled Persons (Employment) Act of 1944, the responsibility for all aspects of the rehabilitation, employment, and placement of the adult blind was assigned to the Ministry of Labour, though local authorities were still obligated to provide sheltered employment for the blind as part of their welfare services under the National Assistance Act, 1948, which repealed and replaced the Blind Persons Act of the past. In implementing the 1948 Act, the Ministry of Labour offered to pay grants toward local authority expenditure for workshops of the blind, and agreed to take over from these local authorities the responsibility for training blind persons over 21 years of age for workshop employment, though young people under 21 remained the responsibility of local education authorities. However, the authorities provided the training in residential further education establishments rather than in the workshops (217).

To an extent not foreseen by the Tomlinson Committee, the blind demonstrated a capacity for semi-skilled and unskilled work in engineering, even after the end of World War II. This trend toward regular employment was accelerated by the publication of a report in 1951 by a working party appointed by the Ministry of Labour to investigate employment opportunities for the blind. This report pointed out that while workshop employment was still considered the normal goal of blind school leavers, a pilot educational institution should be established for blind adolescents whose curriculum would permit them a choice between sheltered and open employment.

As the number of the blind in open employment increased, the number in workshops for the blind similarly decreased, as did those in homework programs. In general the new recruits for the workshops in recent years have been older, less capable, and less adaptable than the pre-war entrants; they have been less suitable for the traditional handicrafts which have remained the chief occupations in the workshops (217).

The Piercy Committee recommended in 1953 that all the blind capable of employment, including sheltered employment in the workshops, be placed under the authority of the Ministry of Labour, an arrangement that was incorporated into the Disabled Persons (Employment) Act of 1958. The Ministry thus became responsible for a total of 3,650 blind workers (of whom 700 are women) in 67 workshops, of which 5 are in Scotland, 55 in England, and 7 in Wales. There are as yet only 27 workshops run by local authorities, the majority being run by voluntary organizations. Most employ both men and women. They vary considerably in size, those in the Midlands and in southern England generally being larger than those in northern England. Premises also vary considerably. Almost all of them engage in more than one trade (217).

Although the traditional crafts of making baskets, brushes, and

mats by hand continue to dominate workshop programs, hand-crafted products are being displaced by machine-made articles except in the making of heavy baskets. Knitting with hand-operated machines is a long-established operation in workshops for the blind. Some are now installing heavy machinery, such as two workshops in London which use machines to make knitting needles and molded plastics. There has been some criticism on the grounds that if the blind can operate machines in the workshop they should be able to operate them in a regular factory, but not all blind workers could be placed in open industry without the special help and supervision they receive in the workshop (286).

The manager of one workshop pointed out that the system of augmenting wages for the blind has one serious disadvantage — it may act as a “disincentive.” Augmentation is a grant and thus not subject to income tax as are earnings. At least two workshops have therefore adopted the practice of permitting the worker to retain a proportion of the earnings above the minimum, without jeopardizing his grant. But workshops cannot generally be expected to be self-supporting, and so the system of augmentation is necessary to assure a living wage (286).

About 180 blind people enter wage-earning employment in the workshops each year, and they come from the following sources:

- (1) from five residential establishments for blind adolescents 16 to 21 years of age. Except at the Birmingham establishment, which is developing a course in light engineering leading to employment in open industry, these give training only in traditional trades, leading to workshop employment. Although they had 100 pupils at the end of 1959, the number of new entrants is falling — from 35 in 1957 to 20 in 1960 and 15 in 1961 — perhaps because of the Hethersett Center and opportunities for open employment.

- (2) from persons trained in the workshops under Ministry for Labour auspices. These are mainly adults, though the workshops do train a few blind adolescents, including Hethersett leavers who are found to be more suitable for sheltered than for open employment.

- (3) from people who enter the workshops as employees without any formal period of training (74 of them in 1961), either because they had had training in a traditional trade at some time previously, or because they are engaged for unskilled work such as labouring or packing which requires no training (217).

In addition to the sighted workers hired by each workshop for certain finishing processes which the blind cannot perform, sighted disabled persons are now more frequently admitted by local authorities when there are no other local workshop provisions available for them, and when their presence means no disadvantage to the blind. By March 1962, 124 sighted disabled workers and 34 trainees had

been admitted to 30 different workshops, and the number is increasing because local authorities are rapidly building workshops specifically to accommodate both the blind and sighted. At present these sighted disabled employees are engaged chiefly in the same work as the blind, in supplementary work such as brushboring or buttonhole-making, or in separate departments on new work such as paper-bag making or medical-appliance making in which the blind are not employed (217).

The availability of appropriate housing and transportation is an important factor in enabling rehabilitated handicapped youth to leave the sheltered workshop for outside employment. Homes for severely disabled groups such as the chronically ill are needed in conjunction with sheltered workshops so that young people who improve sufficiently can move on to them, and also return from them to the workshop if their physical condition deteriorates (226).

Some hostels are provided by both voluntary and statutory agencies. One hostel located in Lancashire is a survival from a period when Polish refugees came to England immediately after World War II. The government does pay some traveling expenses, up to 10 shillings a week, but residents are not expected to travel far to work. A hostel for paraplegic men and women who go out to work—many come from the Stoke-Mandeville spinal injuries unit—was opened in 1949 by the Ministry of Pensions, and then was taken over in 1953 by the Ministry of Labour, which pays part of the operating expenses. Located on the Great West Road on the way to the airport from London, in an area of light industry, it has accommodation for 70 men but only 6 women, since there is little demand for quarters for women. Residents are given some nursing care, for which purpose there is a small nursing staff. In addition, the Ministry of Health provides vehicles for those who cannot walk. Sometimes motorized three-wheelers are used for transportation, as the residents might work as far as ten miles from the hostel, and some return for lunch. Only war veteran pensioners are provided with specially equipped cars. Some men marry and leave the hostel, living in specially constructed homes in that area which are being built at the rate of about one a year by the local authority. There are also some who cannot adjust to the living and working conditions. Some residents are as young as 17 or 18, though these persons usually do not stay long. Hostel residents publish *The Cord*, the editor being a man who lives in the hostel. They also engage in sports activities such as fencing and weight-lifting, which are referred to in *Minilabour*, a Ministry house organ, and some of them participated in the International Paraplegics Sports meeting held in London in July 1963.*

The British Polio Fellowship has a working hostel at Newcastle

* Interview with Miss M. A. Straton, Ministry of Labour, July 1963.

for those working in a sheltered workshop where a retail Christmas card service, silk screen printing, the making of boxes, and the preparing of general publicity materials are the main activities.*

Tuberculous persons are another group for whom a number of separate workshop provisions have been made. One local authority, the Middlesex County Council, has provided a non-residential sheltered workshop, and there are two smaller workshops operated by voluntary organizations, all receiving financial assistance from the Ministry of Labour. Seven of the 89 Remploy factories were originally established as separate units for the tuberculous, but some now accept other types of disability as well, and are therefore closed to infectious cases. Non-infectious cases, on the other hand, may be accepted at any of the Remploy establishments (218).

More important for the tuberculous are the village settlements such as Papworth. The Papworth Village Settlement includes five factories with 700 on the payroll, and a further 300 at the branch establishment Anham-Alamein near Andover. Its products, which include coach-building and other skilled crafts, compete with the products of normal industry. After training, some are able to be placed in open industry when medical opinion permits; others are "colonized" and live with their families in 270 houses and flats on the 1,000-acre estate. There are three hospitals. To be admitted to Papworth the applicant must be able to work at least three hours a day; this is gradually increased to 6 or 7 hours. Those colonized are paid wages agreed upon with the appropriate trade unions. Medical and business management are closely integrated here. The decreased incidence in TB has resulted in fewer applicants, and so some non-tuberculous workers have been admitted to Enham-Alamein (286).

Voluntary groups in general provide workshops for only one type of disability. Sometimes the bequests to the newer societies limit their programs to persons with a specified kind of handicap. An example of this type of provision is the Spastic Society's £500,000 workshop at Harlow for which the foundation stone was laid in March 1964.

Local Authority Workshops

Local health authorities have long had a statutory obligation to provide sheltered employment for the blind, and under the National Assistance Act, 1948, they were for the first time empowered to make provisions for the welfare of other groups of handicapped persons, including provision for employment facilities, subject to the approval of the Ministry of Health. The Disabled Persons (Employment) Act, 1958, transferred to the Ministry of Labour the responsibility for approving programs for sheltered employment. This Ministry now makes grants toward expenditures by local authorities on such services. Local authorities also have the power to sponsor the admis-

* Interview with Mr. Powell, British Polio Fellowship, July 1963.

sion of young persons to sheltered workshops provided by voluntary organizations in special cases to augment their earnings.

An example of local-authority sheltered workshop provisions is that of Middlesex, where as in a number of other areas the adult training center for the severely subnormal is becoming in actuality a sheltered workshop rather than a place where subnormal persons are given busywork so that parents can be relieved for a certain number of hours each day. And as with sheltered workshops for other categories of handicapped persons, it has been discovered that this employment need not be terminal but can serve as a stepping-stone to employment in the open labor market.

Increasing emphasis on preparation of the severely subnormal in adult training centers for jobs in open industry has led to stress on the importance of simulating factory conditions in their training, and of locating the centers (which are actually sheltered workshops) in areas where regular factories are easily accessible. Although it is cheaper to buy land for a center away from an industrial area, the Middlesex authority nevertheless considers that the advantages outweigh the financial disadvantage. The factories are natural sources for outwork for the center; Middlesex has found that the centers are offered three or four times as much work as they can accept, because they are surrounded with factories which can provide such work. This means that there is also virtually no transportation problem, as contrasted with some psychiatric hospitals located perhaps 25 miles away from any industry. It does no good to train persons for jobs which are not available locally. Another advantage is that the management and employees of firms in the area get accustomed to seeing subnormals arrive and depart, and seeing them on the job, so that prejudices and fears concerning them tend to be dissipated. Also when a subnormal person is once placed it is fairly easy to keep in touch with the management of the firm concerning his progress. The cost of industrial equipment for the workshop, and of placement and followup for the personnel, is still considerably less than the indefinite period of provision for those who never leave the workshop. Middlesex also believes that 120 places is a desirable size for a center, rather than a small one, because a greater range of activities, from simple to complex, can be provided, with thus some hedge against recession and loss of particular kinds of work opportunities. In Middlesex there is a balance between work done for the County Council and work done for industry (392).

Hours of work in the center approximate those of industry. The belief that the severely subnormal fatigue easily and cannot work a full day is disputed by the Middlesex authority, which has found that "for the great majority this is balderdash" (392). There are still many places in the other parts of the country where the subnormal workers are given school holidays, but Middlesex objects to this

practice because in industry one cannot expect a factory to close down for 12 weeks every year for this purpose. Another circumstance which approximates open industry is the mixing of the sexes in centers. Middlesex has found that this association results in the subnormal persons' becoming less giggly and feeling more comfortable with members of the opposite sex. While the mixed-sex situation sometimes leads to difficulties in the early stages of trainee adjustment to the workshop program, the workers soon adjust themselves to what is after all a normal way of life (306).

The simulation of factory conditions includes careful consideration of the specific adjustments they will need to make when working in a factory. Time clocks are used, as are canteen facilities which acquaint them with the procedures and the choices of cafeteria eating.

The Middlesex experiments with industrial placement have been highly successful. At first six young men were placed in a factory under the supervision of the authority, working behind screens so that other workers could not see them, and with a legal agreement that they were not to use power-driven machinery. Two years later, there were 60 young persons of both sexes working in this factory, shoulder to shoulder with other employees. Although still under the supervision of the authority, they were working every kind of power-driven machinery in that factory. Also their accident rate was lower than that of other employees, probably because they concentrated well and did not get bored with routine operations. Their work rate as a group was slower than that of their co-workers, but in some instances individuals worked twice as fast as the normal employees.

Here the junior and adult centers are not located side by side, because the Middlesex authority believes "it is perpetuating a sort of Peter Pan approach of going from junior school to senior school" (392). They do find that chronic schizophrenics fit in well with subnormal workers in the sheltered workshops, as indicated by an incident when a distinguished visitor to such a workshop was taken aback by the calm statement of a boy who looked up from his bench and remarked, "The work we are given here is graded according to our individual capacity" (392). An example from the "village community" for the subnormal maintained by the Camphill Village Trust likewise illustrates this ability of the subnormal and psychotic to work together harmoniously in a sheltered-workshop setting. Among a group of young women working in a craft shop producing soft toy dolls, one psychotic young woman occasionally jumped from her electric sewing machine and screamed at the top of her voice. Such episodes, if repeated too frequently, would have presented great difficulty. A Mongolian girl in this group would get up, go over to the excited girl, put her hands on her shoulders, and the psychotic girl would sit down and go on with her work, but no one else could have this effect on her (390).

Homework

Severely handicapped youth who are capable of performing some forms of useful work, but who for various reasons are unable to manage either sheltered or open employment, may be provided with homework either through Remploi or through some other program (286). The traditional occupations for the homebound are the making of soft toys and other handicrafts such as weaving, basket-making, mat-making, and embroidery. Handicrafts teachers visit the homes, take the necessary materials, give instructions, and collect the products, which are sold either at a shop or through retailers or at a market stall or bazaar. The County Associations in Essex, East Sussex, and West Sussex have been particularly successful in their homeworking schemes. Goods must be of good quality and design in order to be salable, and even so, there is competition with mass-produced and machine-produced items.

Another kind of homework scheme is sponsored by local authorities as part of their *welfare* services. Here the homeowner is not expected to be able to earn any substantial part of his livelihood. Earnings over one pound a week are deducted from any grant received from the National Assistance Board.

The Ministry of Labour pays grants to local authorities operating such homework schemes at the rate of 75% for administration (with a maximum capitation rate of £30 per year) and also up to 75% of approved expenditure on working accommodation and equipment. Only two homeworking schemes for the sighted disabled are known to be organized by voluntary societies — one in conjunction with the British Legion Poppy Factory, and the other a clock assembly scheme at Brookwood under the auspices of the Forces Help Society and Lord Roberts Workshops.

The limited success of many homework schemes is explained by the difficulty of finding suitable work and the problems of supervision. There is also a growing opinion that it is better, if possible, to bring the workers together than to give them work at home.

Remploi has a homeworking scheme based at six centers, providing for a total of 112 workers. To qualify, it is necessary to be registered as a disabled person, to be homebound by disability, and to be willing and able to work for a minimum of 28 to 30 hours a week and to earn a considerable contribution toward one's livelihood. The homeworkers are paid at piece rates. A grant is paid during training, and when the worker has become proficient, materials are supplied, finished work is collected, and the wages due are paid only by the supervisor when he makes his weekly visit. Some types of work are making jewelry pads, stringing labels, winding fuse-wire on cards, and rolling and packing adhesive plaster. Light assembly jobs and packaging a variety of small products are other occupations (286).

For the blind who cannot or do not wish to be employed in ordinary industry or in a sheltered workshop, local authorities and voluntary organizations have developed homework schemes providing at present for about 1,100 blind persons. These homeworkers are mainly in business for themselves, and are assisted in the obtaining of raw materials, the advertising and marketing of products, and in technical matters connected with their trade or profession. They usually receive weekly cash payments from the local authority to augment their earnings. They carry on the same kinds of trades as do the workshops for the blind, but they engage in other occupations also such as poultry keeping, piano tuning, shop-keeping, and music teaching. The Ministry of Labour makes grants to the local authorities to help defray the cost of administering homework schemes, and of providing tools, equipment, and working accommodations, but not to augment the blind worker's earnings (218).

The earnings of the blind are brought up to a reasonable level by the local authority contributions, but homeworkers' programs are less adequate for other groups of handicapped persons. The type of work available for home employment is usually such that few of the severely handicapped could earn a reasonable living without working excessively long hours. At the same time a high rate of subsidy would be necessary to bring their earnings above the level of the National Assistance allowances (10).

For the cerebral palsied too severely handicapped to attend work centers, various forms of homework are available through the Spastics Society. In 1957 a program for printing Christmas cards was started, and about 60 are now engaged in this activity (355). A special small machine is used for the printing at home, though color prints are made at a workshop in Bristol, and some cards are commercially produced. There are some problems such as the machines' wearing out and the fact that there are few in the central office who know how to repair them. The target is 350,000 cards printed at home annually.

There is now a new emphasis on jewelry-making; about 100 are engaged in this kind of homework, for which marketing outlets are being developed. Jewelry is found to be a more satisfying product for the workers than baskets, easier to sell, and easier to work with, even for the severely handicapped.* People with the use of only one hand can make costume jewelry, and there is one case of a girl who cannot use her hands at all but who uses her mouth for holding articles. Other homework includes leatherwork, baskets, and rugs (355).

Young chronically ill persons present special problems, for in the present state of hospital provisions they may be confined for life in a ward with elderly or even senile cases since the hospital usually

* Interview with Mrs. C. Clifton, Spastics Society, July 1963.

does not have enough youthful cases to place them in a separate group. At the same time gathering them together in one hospital might make it difficult to preserve contact with their families. If they live at home, there is danger of insolation, apathy, boredom, lack of occupation, and burdensome demands placed on relatives (93). For them Rempoy has a homework scheme for 130 persons, and the British Red Cross also has some activity of this kind.

For those paraplegics who cannot work under normal conditions some form of sheltered employment is provided. Clock assembly work is available as a home industry through the collaboration of the Forces Help Society and Lord Roberts Workshops with the Enfield Clock Company. The Joint Committee, Order of St. John, and the British Red Cross Society have established a settlement for the more severely handicapped at Lyme Green, Cheshire, where men can live in bungalows with medical and nursing care, and repair watches and clocks, boots and shoes under skilled supervision.

In general more research is needed concerning possible kinds of productive work for both homework programs and sheltered workshops. With the latter there has been a gradual shift away from the concept of the sheltered workshop as a terminal point for the handicapped person. It is now more frequently considered a point of transition into a fuller and more effective life in the community if not in the open labor market itself. This concept is similar to that of the "psychologically oriented vocational adjustment workshop" which is developing rapidly in the United States (81).

Chapter 6.

Medical Services

THE SCHOOL HEALTH SERVICE

Among the medical services available to handicapped youth in England and Wales are those provided for all children under the School Health Service. This service, which is under the jurisdiction of the Department of Education and Science, rather than the Ministry of Health, is not a substitute for the National Health Service but is a parallel service. It is based on the assumption that a separate service is the best means for giving growing children the special medical care, both preventive and curative, that is essential to their welfare. Although coordinated closely with the National Health Service, the School Health Service therefore continues as a separate entity, operated by local education authorities to assure the physical and emotional well being to all children in publicly maintained schools. All the medical and dental services provided are free of charge.

A brief summary of the functions of this service is given in a recent publication from the Department of Education and Science:

Local education authorities must make available free medical inspection and treatment and provide a school dental service. While treatment can be and is provided directly by authorities through the school health service, much treatment of a specialized nature is arranged through the National Health Service. The aim of the school health service is to foster the health of all children at school so that they may derive maximum benefit from their education and may leave school the better equipped to undertake responsibilities of adult life; it also aims to provide a counseling service for parents and an advisory service for teachers (56).

The first major provision is for free meals and milk, which became mandatory for local education authorities with the passage of the Education Act, 1944. Earlier this provision had been optional. The Education (Provision of Meals) Act of 1906 was "the earliest example of relief from public funds being given to a specific section of the population by an agency other than the Poor Law, and

hence it marks the beginning of the break up of that formidable structure, and is the forerunner of the social assistance services of the twentieth century" (93). There are still a few local authorities that lack facilities to meet this obligation. Each local education authority employs School Meal Organizers, each of whom is responsible for a group of schools. These officials cooperate with the school staff to maintain school meal standards and also to help in making special provisions for the diabetic child where possible, as in Essex where in 1962 there were 20 diabetics who regularly had the school meal. The social training involved in sharing this meal with other school children is considered to offset the difficulties incidental to the supervision of their diet under these circumstances (94). Nearly 6,000,000 school pupils had milk in school in 1965—about 81% of those in publicly maintained schools and 80% in non-maintained schools, and well over 4,000,000 day pupils were eating school dinners (65%) (53).

A second major provision is for free medical inspection and treatment. The Education (Administrative Provisions) Act of 1907 made mandatory three medical examinations and free medical treatment in elementary school, whereas the Handicapped Pupils and School Health Service Regulations, 1945, specified when these three examinations should occur—immediately after entry to school, in the last year of primary school, and during the last year of secondary school. Some local authorities went further and arranged for a series of four or five of such examinations. However, school medical officers increasingly questioned the desirability of routine mandatory examinations, which are enormously time-consuming both in terms of the examination itself—even though the amount of time per child might average only about five minutes—and in terms of the analysis of a mass of data which might in the end reveal little useful information. Finally the School Health Service and Handicapped Pupils Regulations, 1953, gave the Minister power to approve fewer than three medical inspections of every pupil.

As a result of this change in regulations, local authorities have attempted to improve their medical service in various ways. In many areas selective rather than periodic medical examinations of children in the intermediate age groups are being given a trial, the object being to concentrate medical attention on boys and girls who require investigation, supervision, or treatment instead of on hundreds of thousands of healthy children. All authorities agree as to the importance of the initial examination at the time the child enters school, but the remaining examinations vary. In Hampshire, for example, formal inspection of school leavers has been replaced by an interview; children are only examined if there is some particular reason to do so. The interview takes place in the term before the youngster leaves school. The school leavers' examination has also been discon-

tinued in Oxford City, but in Reading it is considered to be important as an examination of fitness for entry in industry (183).

Routine medical inspections, added to other types of inspections, have often seemed to occupy a disproportionate amount of the pupil's time. One headmistress of a junior school complained about the interruption of her school program by one doctor for a series of medical inspections; by another for diphtheria immunizations; the school nurse for hygiene inspections and for vision testing; an audiometrician for hearing tests; and the school dentist for a survey—all had occurred in a short period of time. Actually most children are now in good physical condition and do not need continuous checking of this kind. Many factors account for their improved health, and the Health Service is but one of these factors. Others are: a rising standard of living; more money available for food and clothing, beyond bare necessities; better housing and new schools; and organized public health measures such as immunization against diphtheria, BCG, and polio vaccination. The family doctor rather than the school doctor is usually consulted in health matters; the latter is consulted only when some educational problem is involved.

One school medical officer emphasized the importance of the change in examination procedure:

The field of the school health service should contract and concentrate on those children who require special help, to enable them to benefit from their education and also to provide an advisory service for teachers and local education authorities. The present type of school medical inspection rarely reveals any significant defects that are not already known to the general practitioner. The number of such cases can be considerably reduced by screening procedures such as vision and hearing testing, which can be conducted by nurses or a clerk. With this comforting knowledge to reassure them, class teachers can themselves make an initial assessment of their pupils' health (60).

Only when such assessment suggests that a child is not in good health should the child be discussed with the school doctor, who if he considers it necessary will get in touch with the family and/or the family doctor. It has been recommended that the case conferences and selective examinations now being used by a number of local education authorities to replace one of the periodic medical inspections should replace *all* routine periodic examinations, and that health problems with little educational bearing should be referred to the general practitioner. This applies to special schools as well, where it should be kept in mind that the school doctor is neither an educational specialist nor an educational administrator (60).

Successful schemes of selective medical examinations are thus characterized by an increased contribution made by teachers and

their close cooperation with the school health service staff. A medical officer, for example, may ask teachers whether there have been any cases of prolonged or repeated absence from school, and then check on such youngsters, perhaps giving more thorough or repeated examinations in these cases. Teachers may also report cases which they feel warrant further investigation, and in some instances they are aided in this process of identification by a list of suggestions concerning the physical and behavioral cues to watch for. A West Riding scheme for selective and more intensive examination was heartily endorsed by headteachers, for they felt that they themselves played a more responsible role in the school health service than before, and there was less disruption of school routine because fewer children had to be taken out of class for examinations. A valuable supplementary device has been a questionnaire for parents to amplify the school record and to aid in selective examinations (183).

The value of school medical examinations, particularly the first one on entering school, has been documented by the number of untreated defects discovered. While some critics have complained that the school examinations merely find defects which have already been noted and given treatment outside of school, there is still a substantial number of untreated cases ascertained. For example, in 1960 in Hertfordshire about half the school entrants with defects needing treatment were not receiving the necessary treatment, and in Plymouth 29% of the defects discovered were not being treated (183). In London, the overall percentage of children referred for treatment of a defect was 12.5% in 1961. Of 20,152 children requiring treatment (except dental and infestation treatment), the largest number (11,347) were those with defective vision, excluding squint. In recent years lung disease and orthopedic defects have shown a continued decline, but psychological defects are increasing. Children were also referred for special medical inspections by head teachers, school health visitors, parents, the divisional education officer, and the Care Committee in that order of frequency (150).

Minor ailments are usually treated by the school nurse, but for more serious conditions free consultative and specialist services, including out-patient treatment, are available at clinics, usually by arrangement with the National Health Service. These clinic services are provided by the Regional Hospital Boards under the jurisdiction of the Ministry of Health. There is close cooperation between the education and health authorities in coordinating their services.

School medical examinations emphasize the preventive nature of much of the school health service, which collaborates with other branches of the health service in the control of infectious diseases, including immunization and vaccination against diphtheria, polio, and tuberculosis. Preventive work includes a broad program of health education, which is now being directed increasingly toward

adolescents through the cooperation of teachers, doctors, school nurses, and health visitors (183). The value of this work with adolescents was stressed in a report by the British Medical Association on "The Adolescent," which pointed out that "neither general practitioners nor consultants see very much of their adolescent patients—less, probably, than of any other age group in their practice, and certainly less than was the case twenty or thirty years ago" (13).

An important aspect of preventive work is the attempt to reduce the number of accidents which so frequently produce death or lasting handicaps. Injury to any one part of the child's body may be serious, but more serious permanent disability is likely to result from injuries to the head or trunk than to the limbs. Even should limb amputation be necessary the child may suffer less handicap in the future than may follow head injury with subsequent epilepsy or severe mental retardation. Although the death rate from head injury showed only a slight rise from 1956 to 1959, the substantial increase in hospital patients with this diagnosis suggest that improvement in treatment of this type of injury has occurred. The age incidence for extradural hematoma differed from that of sub-dural lesions in that the peak incidence fell at 15-to-19 years, and there was no excess incidence in the first year of life (183).

In the report "Health of the School Child 1958 & 1959" it was shown that road accidents accounted for about half the accidental deaths in England and Wales in 1956 at ages 1 to 19 years. Comparable figures for 1959 show little change for children under 15 years of age, despite increasing traffic, but there was a considerable increase (72%) in the number of persons aged 15 to 19 years. Of the 676 deaths in this age group in 1959, 409 referred to motorcycles or passengers. In "Road Accidents, 1960" published jointly by the Ministry of Transport and Scottish Home Department, it was calculated that among 18- and 19-year-olds in Great Britain, one out of every 260 was killed or seriously injured as a result of a motorcycle or scooter accident. Thus in the late teens a person, despite his appreciable maturity, is $2\frac{1}{2}$ to 3 times more likely to be killed on the roads than a child under five years (182).

School nurses and health visitors are particularly important in the program of health education, through their work both in the school and in follow-up visits to children's homes. Teachers call on them more and more for assistance in the more formal methods of health education and in helping individual youngsters through the years of adolescence. More lay assistants are being employed for unskilled duties in order to release the nurses and health visitors for home visits and work with individual children. In Buckinghamshire the appointment of a number of welfare assistants to a primary school that had an unduly high proportion of physically handicapped children made it possible for some of the children to remain at home

and thus stay in the regular school instead of going to the hospital. The home visiting is chiefly concerned with defects discovered by the school doctor in school medical examinations. One of the health visitors on the Isle of Wight has special duties with problem families; during 1960 she worked with 74 problem families which had a total of 225 school children (183).

One aspect of health education that affects adolescents particularly is the increasing emphasis given to the correlation between lung cancer and cigarette smoking. School health statistics showed that in 1961 more than a quarter of male smokers started the habit before they were 16 years old. There is concern about the tendency to glamorize the habit in mass media, which may in part account for the lack of appreciable results from school campaigns against smoking (183).

A 1962 Ministry of Health publication discussed the report of the Royal College of Physicians, London, entitled "Smoking and Health," and urged local education authorities and teachers to make fresh efforts to discourage smoking among children. A committee was set up by the Ministry of Health to coordinate the activities of government departments concerned with this matter, and a sub-committee was made responsible for publicity material (175).

Other problems concerning adolescents include bed-wetting and defective feet and footwear. Although the percentage of persistent bed-wetters (those who had more wet nights than dry ones) decreased with age in one study, the 0.6% of school leavers in this category—which included slightly more boys than girls—must have suffered considerable emotional disturbance as cause or effect or both. There is also widespread concern about the unsuitable and ill-fitting shoes worn by adolescents, especially girls, although boys tend to be nearly as grievous offenders. The girls' shoes may be too long, too narrow, or the heels too high. Many school doctors are pessimistic about the possibility of changing their attitudes toward shoes since fashion continues to dictate the kind of shoes worn by children of secondary-school age (183).

Youngsters are given special protection when they work with radioactive substances and X-Rays. Specific dosage limits are laid down for work in technical colleges, and work in schools is supposed to be at a lower level (183). It is important to note that the death rate from leukemia in England and Wales in males in the late teens is higher than expected in relation to immediately adjacent age groups. This excess is also found in Scotland, the United States, and Canada. Safeguards are described for technical colleges in Administrative Memorandum No. 547 issued by the Ministry of Health on March 29, 1957, and for schools in Administrative Memorandum No. 577, dated October 24, 1958. More potential danger seems to

arise from inadequately shielded X-Ray apparatus than from other radiation hazards in schools.

Dental examinations and treatment are considered a part of the medical services of local authorities. A dental inspection must be carried out as soon as possible after the child enters school, and at least once a year thereafter. Parents are encouraged to be present at both the medical and dental inspections. The medical and dental records, kept on an approved form, follow the child when he moves from one area to another. When special treatment is necessary, the child is referred to the nearest dental clinic, which is operated by the National Health Service. Although the most extensive dental care is thus provided outside the School Health Service, the school dental service still has an important contribution to make in maintaining the dental health of children (183).

Although there has been a large increase during the last decade in the number of dentists employed in the school dental service (the 1964 total was 1,243 [53]), the school dental service is still understaffed, and it is difficult to recruit full-time officers, especially in the younger age range. The improvement in total staffing has not kept pace with the increase in the school population. The number of *inspections* per dental officer has increased year by year, but the number of *treatments* per dental officer has declined. Since 1957 there has been a yearly excess of fillings over extractions (this is due chiefly to the fact that the number of extractions has decreased rather than that the number of fillings has increased). The reduction of the number of children treated each school year in the school dental service is perhaps due to the fact that many children are obtaining treatment under the general dental arrangements of the National Health Service (183).

Many principal school dental officers refer in their reports to two major current difficulties faced by the school dental service: (1) continuing deterioration in the state of school children's teeth, generally attributed to a greater consumption of candy and between-meal snacks, and (2) the acute shortage of dental officers. In most areas the incidence of dental caries is now beyond the capacity of the dental staff to control. As a result much more attention is being given to dental health education; of course quick results are not expected, and some pessimists believe that an educational campaign cannot hope to eliminate or even appreciably reduce children's love for sweet things, especially if their taste for sweets continues to be fostered by well meaning but misguided adults. It is considered important that parents and teachers in particular have the right attitude toward dental care. In spite of the pessimists, there is undoubted value in the dental health education directed at school pupils and to some extent to parents. Such programs include dental health exhibitions (sometimes called Dental Health Weeks), dental health talks and

demonstrations by dental personnel, school meals finished with an apple or carrot, and restriction of sales of biscuits (cookies) and sweets (candy) in schools. In some schools less harmful foods such as fruit, nuts, and raisins are being sold. Both government and voluntary agencies distribute suitable publicity material, such as the Ministry of Health and the Central Council for Health Education. The Standing Committee on Dental Health Education (England and Wales) is a coordinating body and does not furnish publicity material, but it is arranging for a pilot dental health education campaign to assess the effectiveness of the methods used (183).

Another vexing question under discussion is that of the status accorded to the school dental officer and his relationship to the principal school medical officer. It is hoped that a joint circular from the Department of Education and Science and the Ministry of Health will clarify this situation.

Success is reported for an experimental scheme for the training and employment of a new type of dental auxiliary. A study of the value of these auxiliaries is being undertaken by the General Dental Council. Their work will be similar to that of dental nurses but the scope of treatment will be more restricted. The first two-year course for dental auxiliaries, with an enrollment of 60 students, was opened by the Ministry of Health at New Cross, London, in the fall of 1960; a second group was admitted the following autumn. During 1962 the first of these dental auxiliaries to complete this course set up under the Dentists Act, 1956, found employment, so that by the end of the year 41 auxiliaries (expressed as the equivalent of whole-time officers) were working in the school dental service (175).

In a report to Parliament published at the end of 1962, the Select Committee on Estimates reviewed the work of the local authority dental services. The report criticized the administration of the school dental service, and suggested that the responsibility for it should be transferred to the Ministry of Health. The committee were especially dissatisfied with the undermanning of the service—the fact that twice as many dentists were needed to provide the specified annual examination and the treatment service—and with work output as compared with the general dental service. Recommendations were made concerning the performing of more orthodontic work in the school service, and concerning closer collaboration between the school dental service and the general dental service (175).

Child guidance clinics for the treatment of maladjusted children are also provided as part of the medical services of most local education authorities. Many large hospitals contain such clinics, whereas others are sponsored by voluntary organizations. The present total of 336 clinics (some of them part-time) is being increased as rapidly as possible to meet existing needs. Each clinic is usually staffed by a team including a psychiatrist, an educational psychologist, and

psychiatric social workers. Child guidance services are discussed in detail in the next section.

Another major provision of the School Health Service applies specifically to physically or mentally handicapped children, and makes mandatory their ascertainment and supervision from the age of 2 years, and the provision of special educational treatment. It is usually through the school medical examinations that the local education authorities become aware of these children. For both accurate diagnosis and treatment the school health service works closely with the family doctor and specialists, particularly pediatricians. The medical staff of the Department of Education and Science encourage school doctors to carry out surveys and investigations as part of their regular duties, and also they themselves, through their access to the whole school population, study the effects of certain disabilities on the development and educational progress of children. This has led to increasing concern about the problems of handicapped children attending regular schools, and the medical aspects of the learning difficulties of school children. The special educational treatment for handicapped children has been discussed in a separate section on educational provisions.

Some local education authorities make additional provisions as a part of the School Health Service. For example, as a link between the School Health Service and the home, the London County Council has in addition to the school nurse a "Care Committee" attached to each school or group of schools; this committee consists of a group of voluntary helpers working under the guidance of a trained social worker employed by the Council (150).

A continuing problem that besets the School Health Service is a shortage of trained professional personnel. The chief shortages are for dentists, child guidance staff, and speech therapists, but some local health authorities have difficulty in filling posts for doctors and health visitors as well. Most school doctors are employed full-time by local authorities, giving part of their time to the school health service, part to infant welfare, and part to the general public health services, but since the beginning of the school health service some local education authorities have employed general practitioners to work in it. Sometimes school doctors are appointed as part-time clinical assistants in hospital pediatric departments; in turn sometimes hospital pediatricians are appointed to local authority clinics on a seasonal basis. One of the recommendations of the Platt Committee, in the Report of the Joint Working Party on the Medical Staffing Structure in the Hospital Service in 1961, was that a new post of Medical Assistant with unlimited tenure be added to the hospital staff and that these medical assistants might also be employed part-time in the local authority health services. Another useful combination of posts is that of part-time school doctor and

part-time appointed factory doctor, as Herford recommends on the basis of his own experience (103). It is considered of major importance that school doctors, in order to know children, teachers, and parents well, change their posts as infrequently as possible (183).

Another continuing problem is the achievement of closer cooperation and better understanding between teachers and the school medical personnel. Examples have already been given of improvements in the relationship between teachers and the school doctor, a result achieved in part by conferences like the summer school sponsored in Brighton in July 1961 by the National Union of Teachers, in collaboration with the School Health Service and the Society of Medical Officers of Health, on the subject of "Child Health and the School."

In spite of such problems, the general effectiveness of the School Health Service is shown by the fact that most school children were in good health in 1960 and 1961. This represented a steadily increasing percentage over the years; less than one per cent were considered by school doctors to be in unsatisfactory physical condition as compared with almost three per cent ten years earlier (183).

Child Guidance Clinics

The child guidance clinics for maladjusted children are provided as part of the School Health Service. At the beginning of 1965 there were 336 clinics operated by local education authorities, which had provided treatment during the previous year for a total of 46,303 school pupils (53).

The main kinds of clinic, based on an administrative classification, are the following: (1) clinics within the hospital services; (2) clinics entirely under the authority of local authorities; and (3) "joint" clinics organized by local authorities with the psychiatrists provided by regional hospital boards. Each kind of clinic provides the services of a psychiatrist, educational psychologist, and psychiatric social worker (236).

The essential services provided by the child guidance clinic are: (1) a diagnostic service which involves decisions as to treatment, and which may be part of a consultative service for general practitioners, schools, health visitors, child-care workers, etc.; (2) a therapeutic service including treatment of the child, and casework for the parents, whether the child is receiving treatment or not; and (3) an advisory service for workers in schools, health clinics, social services, and residential establishments. The clinical services represent a combination of treatment and community responsibilities that require special skills and experience on the part of the medical director of the clinic (236).

The association between emotional handicap and mental or physical handicap is widely evident. This relationship is illustrated by a

London County Council study of 50 physically handicapped children and their families. Adjustment problems were numerous for the child and for the whole family: 52% of the children showed moderately severe, or severe, degrees of anxiety, as did 56% of the parents; 31% of the parents showed considerable degrees of rejection, and in 18% of the cases one or both parents had deserted the child, either temporarily or permanently. There was also evidence of increased anxiety among 19% of the siblings (68).

According to a Leicester report, the most common problems handled in the child guidance clinic are called behavior problems. These are due chiefly to environmental factors including parental problems and maternal deprivation, but others are due to constitutional factors. Next in frequency come enuresis and the emotional crises of adolescence (183).

Persuasion and tactful insistence are often necessary to see that the family takes the youngster to the out-patient clinic regularly for the prescribed treatment. Care Committee workers in the employ of the London County Council report that medical treatment is seldom refused, but sometimes forgetfulness and lack of interest result in failure to keep appointments unless the worker takes the youngster. This is particularly true when treatment involves attendance at a clinic for enuresis or obesity (112, 113). Families with handicapped children are likely to need care-worker services frequently.

The child guidance service originated in 1913 when the London County Council appointed its first psychologist to investigate cases of children who presented special difficulty. The American child guidance clinics visited by various English observers in the 1920's influenced the development of the clinics in England (151, 153). The number of English clinics increased from 50 in 1939 to 287 in 1961. Voluntary organizations pioneered in the founding of such clinics but by 1945 local education authorities were wholly responsible for 57 and partly responsible for 6 out of 79 clinics in the country (93). The Mental Health Act 1959 gave further impetus to the growth of clinics and psychiatric services. Now in every area of England and Wales there is some child guidance service or some psychiatric or psychological facilities, though the strength of these services varies considerably (183).

Along with the increase in local authority clinics there has been the establishment and growth of hospital child guidance clinics and in-patient units, which provide a closer link with the general practitioner, develop a family psychiatry approach, and stress organic and somatic psychiatry (183). The clinics aim to repair troubled family relationships, and only as a last resort separate the child from the parents (93).

The family approach is illustrated by the work of the Department of Child and Family Psychiatry sponsored by the East Anglican Re-

gional Hospital Board, which has admission clinics for children, adolescents, and adults, including those with marital problems. In addition to helping the child and his whole family, the Department keeps in close touch with the schools and the community. To some extent these integrated services are provided also in other settings, as for instance in the case where the psychiatrist in the local authority clinic is a hospital consultant. Close ties with the schools are necessary since emotional disturbances often come to light there, and because of early diagnosis they can result in more successful treatment.

Children are referred from a variety of sources. In some areas all children are referred through the school medical officer, whereas in other areas referrals come only through the family doctor. There is a definite trend toward medical as contrasted with open referrals. Whatever the system, it is recommended that the one used should include the cooperation of the family doctor. In some areas referrals by the juvenile courts are increasing, though the number of such cases handled by particular clinics depends both on the special interest of the clinic staff in these cases and on the volume of other kinds of cases demanding attention (183).

Classification of youngsters referred to clinics, based on causal factors, includes four categories: (1) mainly reactive, where guidance or manipulation of the environment is needed; (2) mainly psychiatric, including psychoneurosis and psychosis; (3) mainly psychosomatic; and (4) mainly organic. Generally local authority clinics work chiefly with group (1) while hospital guidance clinics include primarily the other three groups (183).

The team approach in child guidance clinics is general, with some variation in the individual roles of staff members. It is increasingly common for the formal case conference to be replaced by informal consultations, though the case conference is retained for its educational value. For such a conference some clinics regularly invite other professional persons working with children. Though there is no standard reporting procedure, it is common practice for the psychiatrist to report to medical colleagues, and the educational psychologist to report verbally to the school staff. However, the psychiatrist in some instances sends an edited report to non-medical personnel and a full report to the principal school medical officer and the family doctor (183).

Accurate evaluation of the effectiveness of the child guidance service is difficult. Three major bases are used for judgment: (1) the response of the people using the service; (2) the assessment made by the child guidance staff; and (3) the results of follow-up studies, although these have been few in number so far because of the problems involved in classifying cases and measuring progress. The apparent success of the clinics is indicated by the increase in their number and in the demand for their services (183).

Though most child-guidance services are provided for children in the 9-to-13 age range, preschool children and adolescents are increasingly referred (183). Referrals related to delinquency tend to reach a peak in early adolescence; one Northumberland study found the peak incidence at 13 and 14 years of age for offenders aged 5 to 21 (13). The turmoil associated with adolescent changes themselves may produce need for child guidance services; one clinic reported that about 8% were due to "emotional crises of adolescence" (183). Fears current among adults can aggravate these emotional problems:

We think that the greater problems of adolescence are insecurity and fear: fear of international possibilities, the hydrogen bomb, and personal relations with their families (13).

The handicapped adolescent shares such fears with his normal peers, though these fears are no doubt intensified by a greater sense of inadequacy, frustration, or worthlessness. The British Medical Association believes that the doctor can help by showing a willingness to listen to an adolescent's discussion of his difficulties, as an essential part of diagnosis and treatment. He can assist mothers of young children in understanding their behavior before emotional problems or delinquency actually develop. The association itself is considering the provision of training courses for parents to give them more insight into adolescent needs (13).

The Child Guidance Inter-Clinic Conference sponsored by the National Association for Mental Health brings together once a year child psychiatrists, psychiatric social workers, and child therapists. At one such meeting, emphasis was given to the need for distinguishing treatment in the clinical sense from punishment, for many of those working with youth have ambivalent attitudes in which the desire to help is mixed with feelings of disapproval and aggression. Emphasis was also given to the importance of working with the family itself to prevent its disintegration:

Chiefly what we have done up to this time is to provide a most expensive ambulance service at the bottom of a cliff when we should be concerned with building a fence at the top (237).

Also parents often do not know about the child guidance clinics, or have mistaken concepts of their functions. For example, it is sometimes believed that the clinics deal only with mentally defective and mentally deranged children. Knowledge of these services might ease problems at an earlier stage.

Current limitations in the services for the family have been summarized in this way:

There is wastage of highly skilled personnel; there are gaps all the way through; there is overlap and duplication. There

is also, perhaps regrettably, friction between empires, and even within one authority five local departments on occasion trying to redefine the areas of their responsibility in order to take over the work (237)

There is also need for more short-term treatment units, residential facilities that can deal with emergencies, more places in approved schools (correctional institutions), higher salaries for personnel in these schools, and a milieu therapy approach. Perhaps local-authority day schools for the maladjusted are the greatest need (237).

The poorest prognosis is for aggressive girls (203). For example, the Emergency Unit of the Portsmouth Education authority has found it difficult to place maladjusted adolescent girls. The special arrangements made with an individual teacher are not adequate. A permanent unit is needed to provide emergency assistance until more permanent treatment can be started, or to give transitional care between school leaving and starting to work (183).

A persisting problem in providing adequate child guidance service is the lack of trained personnel—child psychiatrists, psychiatric social workers, and educational psychologists. (This last title is applied to the psychologists working in the school—who would be called “school psychologists” in the United States—or in a child guidance clinic which is part of the educational services in England—whom we would call a “clinical psychologist.” This last title, which American usage assigns to a psychologist administering tests or therapy in a child guidance or mental hygiene clinic, is given in England only to a psychologist working in a setting such as a hospital clinic.)

In the personnel of child guidance services, the group showing the greatest increase has been the educational psychologists, whose numbers doubled between 1950 and 1961. Still more are needed. A working party was set up by the Secretary of State in February 1965 to study the qualifications, training, and required numbers of educational psychologists, and to make recommendations; this committee received comments and information from many agencies, associations, and local authorities (53).

Educational psychologists have a broad training in education as well as in child guidance. It has been difficult for teachers in service to get financial assistance for this special additional training even though the Training of Teachers Grant Regulations enable local authorities to pay teacher salaries while they are in training. Teachers may also receive free tuition and a grant toward travelling expenses (183).

The clinic staffing objectives for 1965 set by the Underwood Committee for psychiatrists and psychiatric social workers were not met. In 1961 there were 287 child guidance clinics with (in full-time equivalents) 93 psychiatrists, 137 psychiatric social workers,

and 225 educational psychologists, with no chance of reaching the projected 1965 totals of 140, 420, and 280 recommended by the Underwood report (the actual totals in 1965 were 101, 140, and 151 [53]). Psychiatric social workers show the lowest rate of increase and the least likelihood of increase, although local authority mental-health services need the equivalent of 240 full-time persons with this training for their health and welfare services. An increase in the supply of social workers with more general training would relieve pressure on those with professional training (183).

For social science graduates, or those with a diploma or certificate in social science, one-year courses in mental health are available at the London School of Economics and the Universities of Liverpool and Manchester, and 16-month courses at Southampton and Durham. The latter courses which began in 1960-61 consist of a 12-month social science course followed by 4 months of specialized casework. All these courses lead to the Diploma of the Association of Psychiatric Social Workers.

Efforts are made to use existing services as effectively as possible for those in greatest need, in three ways: (1) limiting the area from which cases are referred so that the clinic has a realistic load; (2) introducing improved screening methods before referral, and possibly speeding up the clinic work a little; and (3) increasing staff by employing other than qualified people to do the more routine work. Public-health medical officers are receiving further training in concentrated courses of a week or more, and some local authorities provide lectures and seminars for their own staff (183). Plans are under way to provide opportunities for clinical observation to medical officers, teachers, nurses, general practitioners, and other professional workers in order to enable them to participate more actively in child guidance work.

Although the English criticize their child guidance clinics, the system seems to be better integrated with other services, to serve more persons, than child guidance services in a community in the United States. For the most part, only large American population centers can approach the level of care provided in the English system.

THE NATIONAL HEALTH SERVICE

In addition to the School Health Service, the handicapped youngster benefits from the National Health Service, "an undertaking, by a nation of some fifty million people, to provide *collectively* whatever health care may be needed *individually* by any of all of the fifty million" (82). The National Health Service Act, 1946, became effective on July 5, 1948, just a century after the Public Health Act of 1848 "had first affirmed the State's responsibility for securing minimum conditions of health for the people" (93). Section (1) of the 1946 Act stated that its purpose was "to promote . . . a comprehensive

health service designed to secure improvement in the physical and mental health of the people of England and Wales, and the prevention, diagnosis, and treatment of illness." It made the Ministry of Health responsible for seeing that health services of every kind, and of the highest possible quality, were made available to everyone who needed them. These provisions represented an expansion and strengthening of existing services so that what was once available only to insured persons, to those who could afford to pay for them, and to the indigent, became available to everyone. The health services have thus become rights, without a means test (28).

Such a program of universal free health service represented the culmination of a long period of experimentation and discussion. The service provides a more comprehensive application of the principles embodied in Lloyd George's National Health Insurance Act of 1911, the country's first compulsory health insurance measure, which went into effect on July 15, 1912. At the start the Lloyd George plan covered only about a third of the total population, for while it was compulsory for all manual workers, and for non-manual workers with annual incomes up to £160 or about \$775 in American money, it did not cover their dependents, the unemployed, or certain categories of the employed. Nor did its benefits include specialists, ophthalmic, dental, and full maternity care as provided in the National Health Service Act, 1946 (82).

Although the British Medical Association proposed the Lloyd George plan, it did recommend in 1930 and again in 1938 more inclusive health insurance coverage, and in 1940 issued the Interim Report of a Medical Planning Commission, in cooperation with other important medical groups. Its proposals for a truly comprehensive national health service furnished a valuable basis for Lord Beveridge's famous "Cradle to the Grave" report published in 1942, which led to the 1944 White Paper of the Churchill Coalition Government giving a tentative outline of a comprehensive health service. After the Labor government came into power, the new Minister of Health, Aneurin Bevan, presented the 1946 Act which incorporated the same objectives as the White Paper but made different provisions for achieving them (82). Therefore the Trade Unions claim no little credit for pioneering in the development of the idea of a national health service, campaigning for it over the years, and creating a political party which shaped this idea into law (244).

In spite of the initial opposition and misgivings of the medical profession, the National Health Service Act was passed in the year following the end of World War II, and since then its principles have gained almost complete lay and professional acceptance even though the details of its operation are sometimes questioned. Two major health responsibilities remain outside the National Health Service—the health of the school child and the health of the worker.

Since the School Health Service developed as part of the educational system and was specifically provided for in the Education Act, 1944, it has remained the responsibility of the Department of Education and Science and the local education authorities, though there are some links with the National Health Service. No unified industrial health service has yet been created to function along with the National Health Service, even though there are special laws to protect the worker, and extensive health services are provided by some larger firms.

The public is free to use the National Health Service or any separate part of the service as it wishes. All health services in the program are free except for a few charges to produce some revenue and to reduce "nuisance" surplus demand. Most of the cost is borne by the central government. Nearly all (97%) of the people in England and Wales are enrolled, as well as most of the professional personnel available for medical and health services (82). In round numbers, the service includes 20,000 general practitioners, 10,000 dentists, 900 ophthalmic medical practitioners, 6,000 ophthalmic opticians, 1,000 dispensing opticians, and 16,000 chemists (druggists). Over 3,000 hospitals are within the service. The few remaining outside include some run by religious orders, others such as Italian and French hospitals serving a special group of patients, and still others maintained for the chronically ill or the convalescent by voluntary societies. There are also private nursing homes, which must be registered (28).

Machinery of Administration

The National Health Service arranged for new administrative machinery for health and medical services, a machinery necessarily complex because of the attempt to take into account "the desire of the teaching hospitals to retain their identity, the private practitioners' fears of becoming servants of a central government department or local authority, the value of maintaining services treated and maintained by enterprising and conscientious local authorities" (93).

The services provided under the National Health Service Act are administered in three separate groups: (1) hospital and specialist services; (2) personal practitioner services; and (3) local health authority services. The Minister of Health has direct responsibility for the hospital and specialist services, including research concerning the prevention, diagnosis, and treatment of illness; a Public Health Laboratory Service; and a Blood Transfusion service. He has indirect responsibility for the family practitioner services and local health authority services. These various responsibilities are discharged through executive councils, regional hospital boards, boards of governors of teaching hospitals, and all local health authorities, all composed of unpaid, part-time personnel. In Wales the functions are delegated to a Welsh Board of Health whose members are appointed

by the Minister. The Minister of Health's most important advisory assistance comes from the Central Health Services Council, which reviews the general development of the services, and several Standing Advisory Committees. The Council and committee memberships include both lay and professional talent; most of the members serve without pay (28).

Hospital and Specialist Services

One writer has stressed the importance of the development of these services thus:

Nationalization of the majority of the former municipal and voluntary hospitals, their grouping into regions and management by appointed boards and committees, was the most drastic and far reaching change brought about by the National Health Service Act (93).

On July 5, 1948, the National Health Service inherited from the local authorities and voluntary organizations in England and Wales a total of 2,800 hospitals with approximately 500,000 beds (262). (The term "hospital" of course applies to institutions for groups such as the mentally ill and the mentally subnormal as well as to those establishments traditionally known by this term.) Many of these hospitals were in obsolete buildings; about 45% were originally erected before 1891, and 21% before 1861. Even where modifications had been made later, many were still unsuitable as modern hospitals. Some were no longer well located. Ordinary maintenance was ten years in arrears. Variations in tradition, standards of service, and physical equipment needed to be taken into account. This herculean task was promptly undertaken, as indicated by the fact that between 1949-50 and 1960-61 expenditures on hospital buildings increased from £8.7 million to £23.7 million. Better buildings accounted in part for a great increase in the number of persons served. At the end of 1949 there were 475,418 staffed beds, and just under 3 million in-patients were treated during that year, while attendance at out-patient and casualty departments totaled 26 million and 10 million respectively. In 1960, with an increase of only 1% in staffed beds, the number of in-patients treated rose to over 4 million, and attendance at out-patient and casualty departments rose to 29 million and 12.5 million respectively (262).

The hospital, specialist, and ancillary services are organized into 15 hospital regions, each managed by a hospital board (93). Thus the approximately 3,000 hospitals enrolled in the National Health Service are directed by regional hospital boards except for those designated as teaching hospitals and affiliated with a university having a school of medicine, each of these hospitals having its own Board of Governors (28). The everyday administration of services

in individual non-teaching hospitals is handled by hospital management committees (93).

The 146 local health authorities, which are the Executive Councils of counties and county boroughs, are responsible for health services which have been provided for many years, such as maternity and child welfare, health visiting, vaccination, and the like. They are also responsible for ambulances, home nursing and domestic help schemes, for the maintenance of health centers, and for all other services related to the prevention of illness plus care and after-care, including mental illness and mental subnormality (28). These Executive Councils are in charge of family practitioner services, and are assisted by local committees representing the various professions concerned.

Personal Practitioner Services

Family Doctor Service

The practitioner services include the Family Doctor Service, the Dental Service, the Eye Service, and the Pharmaceutical Service, which together with the local authority services provide a complete range of health services for the community. In the Family Doctor service, patients may choose any doctor they wish, if he is enrolled in the National Health Service and wishes to accept them. The doctor may join the service on either a full-time or part-time basis, or he may remain outside the service. He may have paying patients in addition to his health-service "panel." In difficult cases he is free to secure consultants and hospital service, though once the patient enters the hospital he comes under the jurisdiction of the specialists there. Doctors wishing to enroll in the National Health Service must be approved by the Medical Practices Committee along with Executive Councils, which attempt to ensure an adequate geographical distribution of doctors, but the committee does not tell doctors where they should practice, and rarely refuse an application (28). Doctors cannot sell their practices. The overall distribution is steadily improving, although some industrial and mining areas are still inadequately staffed. The average number of patients on doctors' lists is now less than 2,300.

Payment to doctors for general medical services under the National Health Service is based on recommendations of a Royal Commission which reported in 1960. The basic source of payment is an annual capitation fee of nearly a pound, for each patient on the doctor's list, paid by the appropriate Executive Council from funds provided by the Exchequer. A doctor practicing alone is limited to a maximum of 3,500 patients. Special additional fees are available for those practicing in rural or sparsely populated areas, and for special services such as maternity work, hospital duties, and training assistants. Family doctors work for the most part alone, though some operate private

group centers or work in public health centers, and many have part-time hospital positions as well. There is a steady increase in effective cooperation between the family doctor and the hospitals and local health authorities (28).

Dental Service

All forms of dental treatment are available in this service, in which as in the Family Doctor Service there is complete freedom for patients to choose dentists, and dentists to choose patients and to have paying patients as well. However, in this service patients are not required to register with a particular dentist; they obtain their service by means of appointments. Here too payment is based on recommendations of the Royal Commission on Doctors' and Dentists' Remuneration, which assumed that the average earnings of a dental practitioner should be £2,500 (\$7,000) net. Routine treatment may be given without consulting an outside authority, but in the case of extensive and prolonged gum treatment, inlays and crowns, oral surgery, and most dentures and special appliances, approval must be sought from the Dental Estimates Board. Charges were introduced for dentures in May, 1951, ranging from £25s (\$5.67) to £5 (\$14.00) depending on the number and type of dentures, though no charge is made in the case of expectant or nursing mothers or to children under 16 or still in school. Then in June, 1952, a charge of £1 (\$2.80) was introduced for other types of treatment (or the full cost if less than £1), but there is no charge for nursing or expectant mothers or for children under the age of 21. If dentures are lost or damaged through carelessness, the patient is expected to pay part or all of the cost of repairs or replacement (28).

Supplementary Ophthalmic Service

The supplementary ophthalmic service for testing sight and supplying spectacles forms part of the eye services available under the National Health Service. Those needing special treatment or unusual spectacles are referred to the family doctor, who in turn can refer them if necessary to the Hospital Eye Service. Specified fees are paid by the government to the ophthalmic medical practitioner or ophthalmic optician for testing sight, and to the optician or dispensing optician for professional services and spectacles. Sight testing is free to the patient, but as of May, 1951, a charge was introduced for spectacles £1 (\$2.80) for each bifocal lens and 12s. 6d. (\$1.75) for each other lens plus the actual cost of the frames. The fees for lenses and frames were increased as of August 1, 1965 (195). There is no charge for children's spectacles, or for repairs or replacements unless resulting from the patient's own carelessness. Some help in paying for new spectacles or frames can be secured in hardship cases from the National Assistance Board (28).

Pharmaceutical Service

Through the Pharmaceutical Service, everyone receiving treatment under the Family Doctor Service is entitled to free drugs, medicines, and certain prescribed appliances as part of that treatment. Appliances not covered by this service can be supplied through the hospitals. Whereas before December 1956 there was a charge of 1s (14¢) per prescription, there was after that date a charge of 2s. for each item on each prescription form made out by the doctor. In country districts where the doctor did his own dispensing the charges were payable to him. Such charges could be refunded in certain cases, as to needy persons and National Assistance recipients. The medicine itself, whatever it costs the government, was free to the patient, unless he was a private patient (28). As of February 1, 1965, however, the charge of 2s. per prescription was abolished "in order to remove any financial barrier to patients in seeking necessary medical treatment" (195).

The hospital and specialist services provide all forms of hospital care and treatment for both in-patients and out-patients in every kind of hospital, in maternity homes, tuberculosis sanatoria, infectious disease units, institutions for the chronically ill, convalescent homes, and rehabilitation centers. Specialist opinions and treatment are available in hospitals, clinics, or when necessary in private homes, and there is in addition a blood transfusion service, a pathological laboratory service, and some provision for the after-care of hospital patients. Several diagnostic ear clinics have recently been established in hospitals, and hearing aids are supplied to patients referred from clinics at distribution centers; these aids are also serviced without charge. Special attention is now being paid to tuberculosis, venereal disease, and mental subnormality.

All these services are available to everyone, usually through referral by the patient's family doctor. Treatment and hospital care are free, but in June, 1951, charges to out-patients for medicine, dressings, and appliances were introduced (28).

Like the general medical practitioner, the specialist may join the health service or not, and if he does join, he may do so on either a part-time or full-time basis, taking on private patients in addition if he prefers. But unlike the practitioner, who receives a fixed annual capitation fee for each of his patients, the specialist is paid a salary, the amount of which is determined by his rank and length of service in the program. Efforts have been made, as with the family doctor, to secure a more satisfactory geographical distribution of the specialists (28).

Although hospital service is available for the patients of the family doctor, the health service emphasizes the desirability of treatment at home wherever possible, so that patients are sent to the hospital chiefly for special treatment only obtainable there or when the home

situation is unsuited to their care. The general practitioner can call a specialist to the patient's house, and the number of these home visits is steadily increasing. Should the patient be sent to the hospital the assumption is that he will be released as quickly as his physical condition permits, follow-up treatment being given in the hospital out-patient department, or at home by the family doctor or the home health service.

An expanded program of hospital building and capital improvements in existing hospitals was begun in 1956. The health departments give the hospitals advice through "Building Bulletins" and "Building Notes." Both statutory and voluntary funds are being used for this expansion program.

Mental illness is handled in much the same way as physical illness. Emotionally disturbed patients can consult the family doctor or receive specialist advice at hospital out-patient clinics, or if necessary, enter a hospital for treatment without any formalities. In cases where the patients or their relatives are unable or unwilling to make the necessary arrangements for admission to a mental hospital, it is the duty of a mental welfare officer of the local health authority to do so. Compulsory detention of a patient in a mental hospital is regulated by the Mental Health Act, 1959, with certain procedural safeguards to protect the individual from unnecessary detention; he or his relatives may appeal to a mental health tribunal, an independent agency designated by the Lord Chancellor that is found in each of the 15 hospital regions in England and Wales (28).

There are special rehabilitation facilities in the departments of physical medicine and occupational therapy at the main hospitals, and in a few special rehabilitation centers not attached to any hospital, where a team of medical specialists includes physiotherapists, remedial gymnasts, occupational therapists, and social workers. These departments work in close cooperation with the Disablement Resettlement Service of the Ministry of Labour. Rehabilitation services have been used successfully with the chronically ill, the aged, and the handicapped (28).

Many hospitals have an "almoner's" department staffed by medico-social workers who apply the principles of social case work to the problems of hospital patients. They are concerned with the patient's personal anxieties and family problems, and provide after-care and continuing help with adjustment to normal life. Social work in psychiatric clinics and hospitals is carried out by another type of social worker, the psychiatric social worker (28).

Among the many suggestions for improving hospital services for the handicapped is one concerning the chronically ill adolescent (accident cases, congenital disease, early cases of Parkinson's, disseminated sclerosis, some form of muscular dystrophy, etc.). Since no one hospital usually has enough of these young chronics to make a

separate group of them, it is recommended that hospital management committees set aside a ward for boys and young men and a ward for young women of the whole area, and plan to keep these young people as active and independent as their state of health will allow (226). Though objection to such groupings is often based on the possibility of concentrated heavy nursing responsibilities, with difficulty in staffing, some of these young patients would not need extensive care, and much could be done by using part-time married nurses and orderlies, perhaps even relatives.

Convalescent care for persons discharged from the hospital can be provided by the National Health Service either in homes maintained by the Regional Hospital Board or by arrangement in voluntary homes, more of which are needed to meet the demand. "Recuperative holidays," while not the responsibility of the National Health Service, may be provided for the handicapped or convalescents by local authorities, who need more short-stay hostels for this purpose (28).

Local Health Authority Services

The local health authorities are the county councils and county borough councils, though joint boards are sometimes found desirable. The 146 major local health authorities work through health committees to provide maternity and child welfare services, including welfare centers, maternity care, dental care, and day nurseries; services for the prevention of illness, care and after-care, including vaccination and immunization, health visiting, home nursing, and domestic help; the ambulance services for sick or mentally defective persons or expectant mothers; and the provision, equipment, and maintenance of health centers (28). In some areas the health committee of the council assumes responsibility for both health and welfare services, whereas in other cases there is decentralization through the use of sub-committees of the county health committee. The services assigned to the local authorities are mainly preventive in character (93).

Among the most important responsibilities of the local health authority is the provision of maternity and child welfare services, including clinics for ante-natal and post-natal care for mothers and health supervision of children, as well as employment of domiciliary midwives and health visitors. Local executive councils are responsible for maternity medical services undertaken by general practitioners, while the regional hospital boards are responsible for maternity hospitals and associated consultant services. Some have criticized the division of responsibility for services versus a more unified maternity service (93).

In the maternity and child welfare centers, ante-natal and post-natal clinics include doctors, health visitors, and midwives. The health visitors and midwives visit the homes to give advice and help

to mothers and encourage them to attend the clinics; they often detect illnesses and defects which might otherwise have been detected and treated at a much later date. More than three-fourths of the babies born in England and Wales are brought regularly to these clinics for supervision of their progress and development until the age of five years. Special sessions are held at the welfare centers for early testing of babies for deafness and other defects. If treatment is required, the child is referred to the family doctor, who in turn may seek specialist advice in a clinic or hospital. As indicated earlier, local health authorities must provide free dental care for mothers and young children. The health instruction given these mothers may take the form of individual consultations, group discussions, demonstrations and special classes, or in some areas, evening clubs for mothers or parents. A wide range of ante-natal and obstetrical services is available through the doctor, midwife, consultant obstetrician, and health visitor. The increasing number of women who have their babies in the hospital usually have both ante-natal and post-natal care as hospital out-patients. Other services include a domiciliary premature baby service, day nurseries, child minders for children under 5, and special provisions for unmarried mothers and their children (28).

Like other social services, the child welfare services grew up piecemeal as a combination of the pioneer efforts of private individuals and of local medical officers of health. Early fears that such services would destroy a sense of family responsibility and the underlying values of family life have proved largely groundless (93).

The health visitor has become an active and important member of the maternity and child welfare team. The organization of health visiting by women paid for the work was first undertaken in 1862 by a voluntary group, the Manchester and Salford Ladies Sanitary Reform Association. This idea was taken up by various local medical officers of health, although until 1948 the role of the health visitor, like that of the school nurse, was chiefly that of mother and child care. After the National Health Service Act, her role was broadened in scope to include advice concerning the care of an ill person and means for preventing the spread of infection. Many health visitors take part in a care and after-care program and work closely with general practitioners and hospitals (93).

Home nurses (often called district nurses) serving people who need nursing care in their own homes are employed either by a local health authority or by a voluntary organization acting as the agent of this authority. Their use dates from 1859, when William Rathbone, a Liverpool merchant, started a system of district nursing by trained nurses in that city, an experiment adopted thereafter by many towns and cities throughout England (93). Over half the nurses' time is now devoted to caring for the aged or chronically ill; their duties

are also increased by the earlier release of patients from the hospital. Local health authorities can also provide domestic help in households where it is needed because of illness, confinement, or the care of children, old people, or the "mentally disordered"; charges for this service are adjusted to means. Here too the aged and chronically ill absorb most of this service, with maternity cases next in frequency. Some authorities provide a night service to sit up with patients or old people and give relief to other members of the household, and some authorities use the home-nursing service to prevent the breakup of families during the temporary absence of an ill mother (28). Another recent development has been the use by certain authorities of selected "home helps" to assist in the rehabilitation of problem families (93). There has been a steady annual increase in the use of home nurses and home help, even though the latter are usually paid for on the basis of means (82).

Measures for the prevention of tuberculosis are the responsibility of the local health authority, whereas facilities for diagnosis and treatment come under the hospital service and are provided through sanatoria and chest clinics (28). The Tuberculosis Act of 1921 made it a statutory duty for all county councils or county borough councils to make provisions for the tuberculous that included dispensaries, which were local centers for diagnosis and treatment through which all cases of tuberculosis would pass, at which contacts would be examined and from which educational work and after-care would be carried out. When the hospitals and sanatoria were taken over by the Regional Health Boards as a result of the National Health Service Act, the dispensaries were transformed into, or replaced by, the "chest clinics." The new organization of services presented the possibility of a closer link between the tuberculosis service and general hospital service, though some felt it meant a division between preventive and treatment services (93).

Among the duties of the staff of the clinic is recommendation for residential treatment, for visiting patient homes, and for examining and advising "contacts." Assistance is given by tuberculosis health visitors, nurses, almoners, and other kinds of social workers. Mass miniature radiography has been an effective means of early detection. Care and after-care of patients is supplemented by general advice and assistance to their households such as erection of chalets in the patient's own garden, beds and bedding to enable him to sleep alone, help to the family in finding better accommodation, and arrangements for boarding out the children of infected parents. Local health authorities send patients to village settlements for the tuberculous run by voluntary bodies or by local health authorities in other areas. Training for employment is carried out in conjunction with the training and resettlement arrangements of the Ministry of Labour (28).

Care and after-care provisions can be made by the local authority for other types of illness as well. There is recognition of the value of and need for the "domiciliary team" to assure the patient being treated in his home the same team service available to the hospitalized patient. Local arrangements for this purpose must be made by the general practitioners, hospital staff, and officers of local authorities working together. Mental illness is included in provisions for care and after-care; in fact, there is increasing stress upon the role of the community in facilitating the recovery of the mentally ill (93).

Local authorities employ many social workers in their health and welfare services, including professionally trained medico-social workers or almoners, and psychiatric social workers. As a result of a recommendation of a Working Party which reported to the Ministry of Health in 1959, a new general training in social work is provided outside the universities, in addition to existing professional courses. These new courses started in September 1961 at Colleges of Further Education in London, Birmingham, and Liverpool. Legislation was introduced at that same time to set up a Social Workers Training Council to promote the new training, as recommended in the Working Party report (28).

Special arrangements for vaccination against polio were extended in 1960 to all persons up to the age of 40 as well as to certain others. Since the beginning of 1961, persons not included in the special arrangements can be vaccinated by their own doctors. In addition BCG vaccination includes school children age 10 and up, and students attending universities, teacher-training colleges, technical colleges, or other further-education establishments (28).

There are still many teenagers in the country who have not been vaccinated against polio. The Bristol Medical Officer of Health found this group to be a problem for two reasons: (1) if they are under 21 they must have parental consent before being vaccinated, and many will not bother to do this; and (2) though Salk vaccine became available as early as 1956, and strenuous efforts have been made to persuade parents to have their children vaccinated (including a big school campaign in 1960), there are still many young people who left school between 1956 and 1960 who have never received any polio protection. An amusing but effective expedient to remedy this difficulty was used by the Bristol medical officer, who sent a team of white-coated nurses to a local ballroom when it was packed with youngsters. In one session 450 Bristol teenagers received their dose of vaccine on lumps of sugar during a breather from doing the twist. At a second visit some 300 doses were given (385).

The health centers which local health authorities are employed to establish and maintain are designed to provide facilities under a common room for any or all of the major types of service allocated to practitioners, specialists, and local health authorities (28). It was

intended that there should be one health center for every 10,000 to 15,000 people, with consulting rooms for 7 or 8 doctors working as a team, but in actuality only a few such health centers have been established, because of various factors such as shortages of money, materials, and personnel (93). Another factor has been a growing belief that the services to be provided by health centers are adequately, or even more adequately, supplied by the many existing practitioner partnerships and group practices, the latter having been encouraged by the creation of a Group Practice Loans Fund in 1953 (82). By July 1, 1958, more than two-thirds of general practitioners were members of partnerships of which nearly half comprised three or more doctors.

An example of the team approach in providing services under the National Health Service is that provided for the young amputee. Both correct prescribing of a prosthesis, and training in its use, are recognized as important. All children are checked repeatedly at the hospital clinic to be sure the fit of the prosthesis keeps pace with growth; they also return for training in its use that is commensurate with their age and educational development. The kind of limb prescribed varies with the patient; a young manual laborer living in the country might require a different limb from a white-collar worker in the city, and a young female arm amputee might feel that appearance is more important than function. In every case, the whole patient and his environment is taken into account by those working with him. Thus the Ministry of Health's medical officer in charge of the case and the prosthetist consult constantly at all stages concerning the fit of the limb. The program of arm training or walking training prescribed by the medical officer is carried out through occupational therapists (for arm training) and physiotherapists or remedial gymnasts (for walking training). Close liaison is maintained with the family doctor. Every primary case is reported to the Central Statistical Records Unit of the Ministry on completion of a course of training, with a follow-up report a year later and further major surgery recorded as it occurs. If a patient has not appeared for help or service for a year, a questionnaire is sent to him (322).

The diagnosis and treatment of epileptics is carried out within the general framework of the National Health Service. Epileptics may be under the care of a general practitioner, attend the neurological department of a hospital for examination and treatment, or attend one of a few special clinics exclusively for epileptics. There are also epileptic colonies for those who cannot be cared for at home; here the treatment but not the residence falls within the National Health Service. Some epileptics who need treatment as mentally disordered persons are cared for in psychiatric hospitals within the National Health Service (218).

Treatment is limited in most cases to the administration of appropriate drugs. Neurological examinations may throw light on the degree and nature of the disturbance and causes such as brain tumor or brain injury. If the medical treatment is carefully followed the epileptic is usually able to live a normal active life; inactivity—mental and physical—is regarded as more harmful than over-activity (218).

Voluntary organizations work hand in hand with public agencies in providing for the health and welfare of the general public. Some have been absorbed into the National Health Service whereas others simply receive a subsidy. Their provisions of personal service and personal interest continue to be important. Most hospitals have their own "Leagues of Friends" or similar groups of voluntary workers who operate canteens for out-patients, provide a library service, receive new patients, visit in the wards, and mend linens (28).

Problems Faced by the National Health Service

Among the continuing problems faced by the National Health Service is that of steadily increasing costs, in spite of service charges introduced in the past decade, the introduction of the weekly National Health Service contributions (28), and the doubling of the rate of insurance contributions by the National Health Service (Contributions) Act, 1957 (93). These contributions are paid as part of the combined weekly insurance contribution at the rate of 3s. 4d. for an employed man and 2s. 10d. for a self-employed or unemployed man, the rates for women being lower (195). Such contributions in 1965 provided 13% of the total cost of the National Health Service. Cost increases are due to such factors as rising prices and staff salaries, higher cost of drugs and modern equipment, increased public use of the services provided, the advancing age of the population, extensions and improvements of the services, and capital expenditures. When National Health Service costs are corrected for changes in the general price level, they appear to have increased enormously, but if one considers the *proportion* of the gross national product required to carry the service, it is found that the percentage stays about the same from year to year, 4% or a little less. The funds for the service come from national and local taxes, patient payments for services with specific charges, pension contributions withheld from NHS salaries, transfer payments from the National Insurance Fund, and direct NHS contributions now required of all employers, employees, and self-employed persons (82).

The proportionately high cost of hospital and specialist services is a matter of great concern, since these take about 63% of the total National Health Service expenditures, contrasted with 28% for general practitioner services and 9% for local authority services. At present there seems to be no satisfactory way to cut costs and

still maintain optimal services, or to reapportion current expenditures. The Guillebaud Committee Report on the cost of the National Health Service indicated that the growth of medical knowledge adds constantly to the number and expense of treatments, and by prolonging life increases the incidence of slow-killing diseases (82).

Another problem, already referred to, is that of shortages of professional personnel. Recent attention, for example, has been given to the need for adequately trained hospital administrators, the permanent officials who carry the main burden of day-to-day functioning of the hospitals (93). The Ministry of Health has now sponsored a plan for a three-year training course for selected candidates, given at King Edward's Hospital Fund Administrative Staff College and at Manchester University, and hopes to extend present opportunities for refresher courses and part-time training for men and women already in service. Beyond the problem of an adequate supply of well-trained professional people, of course, is that of disparity in their geographical distribution such as exists to some extent today in the case of doctors, hospitals, and specific local authority services.

Still another problem continues to be that of securing maximum coordination of service. An illustration is found in the provisions made for the care and treatment of tuberculosis. Under the National Health Service Act the regional hospital boards took over hospitals and sanatoria as well as local dispensaries, which became "chest clinics," whereas local health authorities continued to supervise notifications, health education, and examination of contacts. Mass radiography comes within the province of the regional hospital boards, but immunization is the responsibility of the local authority, the BCG vaccinations may be carried out by chest physicians for the county council or county borough council. Local responsibility for care and after-care means providing special tuberculosis welfare services and using the services of district nurses and home helps, but it also means seeking the help of other statutory and voluntary organizations such as the National Assistance Board and the rehabilitation services of the Ministry of Labour. Thus some interdependence of prevention, treatment, and after-care—of hospital treatment and community care—characterizes other medical conditions also. Therefore closer cooperation of various groups serving the public, more attention to the prevention of illness, and higher standards of care, especially domiciliary care, remain important objectives (93).

Gemmill in his survey of British attitudes toward their health service found frequent reference to the need for more dentists and nurses, more general practitioners with smaller lists of patients, more adequate health provision for the aged and the mentally ill, more capital investment in hospitals, more pay for doctors and nurses,

more emphasis on preventive health measures, and better integration of all parts of the service (82).

Since serious physical ailments and mental-health problems affect relatively few adolescents, general practitioners and consultants see much less of their adolescent patients than of any other age group in their practice, and certainly less than they did 20 or 30 years ago. The less doctors see of them, the less incidental help they can give them with emotional problems which might be discussed during a medical visit. Although the handicapped adolescent has more occasion for contact with the general practitioner or specialist than does the non-handicapped adolescent, even with him the doctor's understanding of personal problems intimately related to the handicapping condition may be limited by the fact that he has so little time, and also by the fact that he has had little or no preparation for giving help with emotional problems (13).

In spite of the problems that beset the service, the positive results of the system include a steady improvement in the country's vital statistics (such as reduction in maternal and infant mortality rates), a decrease in invalidism from neglected ailments, and the removal of anxiety about the cost of treatment. Modifications and improvements continue to occur as shown by the succession of further National Health Service Acts passed in 1949, 1951, 1952, 1957, and 1961 (28). A bold venture undertaken during the period of reconstruction following World War II, the National Health Service has gained almost universal acceptance throughout England and Wales for its general policies, and wonder is often expressed that in spite of what some consider to be its operative shortcomings, the service on the whole works so well (93).

MEDICAL SERVICES DURING EMPLOYMENT

Industrial health and medical services supplement the care available to the school leaver as an adult.

Industrial health services are essentially preventive and include first-aid treatment for cases of accident or sickness. The present industrial health services have grown from two principal sources: the State and the employer. The State has appointed inspectors, including medical inspectors, to advise on and enforce the increasing volume of enactments concerned with the health of the workers particularly in the mining, manufacturing, construction and power supply industries and in agriculture. Employers have a general responsibility not to endanger the life and health of their employees and many have made arrangements, including the engagement of doctors and nurses, both to help to comply with the statutory requirements and also in a spirit of enlightened management (28).

In addition to 19 medical inspectors of factories in the Factory Inspectorate of the Ministry of Labour, there are over 2,000 factory doctors appointed by the Chief Inspector of Factories to carry out the required medical examinations in factories, and to investigate cases of notifiable industrial disease and certain accidents. Medical supervision of workers is also supplied in some factories by industrial medical officers appointed by the employers; it is estimated that about 1,500 doctors and several thousand nurses and assistant nurses are so employed. In a few places some smaller firms have cooperated to provide a joint industrial medical service. Shops and offices are regulated by acts applying specifically to them, e.g., the Shops Act, 1950, and the Offices Act, 1960 (28).

The Appointed Factory Doctor provides one of the types of medical service available for young people after they leave school when they work in industry. This provision goes back to the Factory Act of 1833 which required a doctor's certificate for all children in the cotton mills, to indicate that they were apparently nine years old and reasonably fit. In 1844 Factory Inspectors were empowered to appoint Certifying Surgeons to examine young people, though other doctors could give a certificate of fitness if it were countersigned by a Justice of the Peace. After this permission was abolished in 1878, a Certifying Surgeon was appointed for a specific district, of which there are now nearly 1,800. The role of the Certifying Surgeons expanded to include cooperation with Factory Inspectors in furthering the educational opportunities offered as part of factory programs, and improving working conditions. Since 1901, the Certifying Surgeons have had the power of Inspector of Factories to examine the employment activities of young people and grant certificates after personal examination at factories employing more than three young persons. No one under 16 could be employed without such a certificate (103).

Increasing dissatisfaction with this system led to a special report in 1924 on young persons in factory employment. Some of the recommendations from this report were incorporated in the Factories Act of 1937, which made the certificate a positive one instead of merely noting the absence of disease, and which also changed the title of Certifying Surgeon to Examining Surgeon. In the Factories Act, 1948, the age limit for examination of juveniles was raised from 16 to 18; a young person remaining in the same employment for a year is subject to reexamination at the end of that year and each succeeding year until the age of 18. As before, all below the age of 18 must be examined within 14 days of beginning employment. The 1948 Act also changed the title of Examining Surgeon to the present title of Appointed Factory Doctor (103).

The Chief Inspector of Factories appoints the factory doctor and assigns him to a particular district. For most of these doctors the

position is a part-time one, and nearly all of them are general practitioners. Their duties are (1) to examine young persons aged 15 to 18, and (2) to supervise periodically the workers in specified kinds of employment, in connection with which they may be called upon to investigate certain cases of industrial disease or accident. The Appointed Factory Doctor has the power to refuse employment or to impose conditions of employment.

The duties of the AFD as specified by the Ministry of Labour are to determine general fitness for employment, and to discover defects that might affect suitability for employment. Usually the examination and recording of pertinent information occupies about 15 minutes on the average for an initial examination, or 7 minutes for a repeat examination within a year when employment is changed.

Opportunities exist for fruitful collaboration between the youth employment officer and the Appointed Factory Doctor. In a study of Slough and Eton school leavers, the Youth Employment Service supplied lists of school leavers (except for grammar schools) which made it possible for the AFD, when a youngster was placed or came for his insurance card, to inscribe opposite his name the type of work and the firm to which he had gone. It was thus possible to determine how many had entered industry and which firms should report juveniles for examination. Provisions could thus be made not only for the initial examination on entering employment for the first time, but also for notification of employers of the need for re-examination of those changing jobs, and providing special records to make possible a complete follow-up of all young persons who had not been seen for a year. Many employers, especially in the smaller firms, did not fulfill their statutory duty to report juveniles for examination, particularly for annual re-examinations. Such oversight or neglect was especially detrimental in the case of handicapped youth (103).

Since nearly 50% of all children who leave secondary modern schools enter occupations subject to supervision by the AFD, it will be appreciated that the statutory duties of the AFD give him exceptional opportunities for contact with young people. During the stress of adolescence he alone sees them on entry into industry, every time they change jobs, and once a year up to the age of 18 if they remain in the same employment. He should therefore know why they take and why they leave jobs, and what they feel about their work and future. It is his duty to see that they are fit for the job, and that the conditions under which they work are satisfactory. He should be in close touch with the School Medical Service and the Youth Employment Service, and with the young person's own doctor if special supervision or action is required. . . . The AFD has exceptional opportunities for co-operation with employers, trade unions

and personnel workers to foster the welfare of young people (103).

The AFD has important functions to perform for handicapped as well as non-handicapped youth. For he not only serves those youth already classified as handicapped at the time they begin employment, but he also may discover handicapping conditions not reported at the time employment begins, either because the young person did not wish to have the condition known, or because the condition had not previously been diagnosed as a handicap. Dr. Herford, in his three-year study of AFD services to Slough and Eton school-leavers from secondary-modern and technical schools (80% of whom entered employment at age 15), found that 6% of the boys and 6.37% of the girls had major defects, previously undetected. He defined a major defect as one which will be likely to affect the person's future working capacity and general capacity for employment (in contrast to the school medical service definition of a handicapping condition as one related to the individual's ability to profit from an educational program). Although the number of major defects discovered was relatively small, numerous minor defects were ascertained. In a few instances tuberculosis was diagnosed after a youngster was indicated as fit in his examination, because of limitations ascribed to the examination procedure used (103).

Most of those with cardiac disease were not on the Disabled Register and found little difficulty in getting employment, though it was sometimes unsuitable. The main problem was for the Appointed Factory Doctor to keep in touch with them and to see that they did not over-tax themselves.

Since it was desirable not to make the youngsters "heart-conscious" and to respect their wishes for certain kinds of jobs or fellow contacts, a discussion with employer or supervisor might reveal a possibility of compromise.

The question arises whether it is better to live a few years less and enjoy freedom or to impose restrictions which may prolong life but prevent full enjoyment. It may be that a free, shorter life is better than a longer one burdened by a neurosis (103).

There was perhaps more difficulty in handling these cases than any others.

In eye defects, errors of refraction were nearly twice as common in girls as in boys. But gross defects of vision were more common among boys; this was perhaps due to the higher accident rate through damage from branches of trees, air guns, stones, and arrows. In many ways the most important type of defect found was uncorrected or insufficiently corrected squint, the importance lying in the combination of visual defect with the psychological aspect of deformity.

Improvement in eyesight has a beneficial effect on employment and reduces the tendency to change jobs. Herford raised many questions about the adequacy of eye-testing procedures and supervision at school. Among these questions are the following: How satisfactory is the Snellen chart? How often should eyes be tested? Is there adequate supervision of those with defective vision? Should there not be some special system for insuring that all children are tested thoroughly (rather than routinely) before leaving school? Should not visual defects requiring some supervision be reported to the AFD? He urges closer cooperation among the School Medical Service, Youth Employment Service, AFD, and general practitioner, especially to provide follow-up and action (103).

There were only 15 juveniles on the Disabled Register in industry in that area, but Herford felt that many more might with some benefit have been placed on the register. Parents are sometimes reluctant to allow their children to be placed on the Disabled Register, and are ignorant of the value of special training. If the physically and mentally handicapped were given vocational training before leaving school, perhaps a decision could be made as to whether they would be placed on the register.

Herford also found that:

Not many of those with a disability qualifying them for the Disabled Register are doing or trying to do a job that is too hard for them. While they are young and have no responsibilities or particular need for money, and jobs are plentiful, their disability generally represents a minimum handicap (103).

There is also difficulty in making certain that registration helps those who most need help, and facilities for training are inadequate. The problem is actually a long-term one; what might happen to these young people in the future, say in ten years? Most disabled youngsters were intelligent enough to profit from special training but many would no doubt have found it difficult to realize the need for disciplining themselves to make the effort even of attending night school.

In some cases a low level of educational achievement resulting from prolonged or repeated absences due to illness or parental indifference restricted the scope of light work in an office, as in the case of poor readers. Those with a disability and only moderate intelligence may not necessarily find a government center the best place for them; cooperation between the AFD and the Youth Employment Service might meet their needs.

It was often difficult to decide whether the mentally handicapped should register. Over half of those studied who were mentally retarded were doing better than their supposedly more intelligent companions. The school record was not necessarily a good index of their

potential adjustment to the job situation. There were few general interests, and little interest in belonging to youth clubs. The main difficulty in placing the less intelligent youngsters was not in finding suitable work for them, but in finding workmates and a foreman with understanding and patience. Many more such youngsters could be accommodated in the routine jobs which more intelligent persons find tedious and dull. Training should be given immediately on reaching school-leaving age, or even before; it could be given in special centers to which firms could sub-contract routine tasks of production or assembly. Or these centers could even give permanent occupation to those who could not develop further. Others could eventually be sent to selected factories where workmates and staff understood their special needs. The Regional Hospital Board had the power to open recuperative and rehabilitation centers to relieve pressure on, and save the expense of, regular hospital services, and they could open training centers and hostels to relieve pressure and expense for mental hospitals which are under their control. Such centers could give early training for industry and save young defectives from being institutionalized.

Neurotic or psychosomatic symptoms appeared in 5% of the youngsters. Few paid visits to their doctor. The average doctor has perhaps too little time, inclination, or special training to give psychiatric help, whereas the youngster might feel it would be an admission of deficiency to see a psychiatrist as such. Excessive job-changing is more likely to be a sign of immaturity than genuine emotional disturbance.

There are various ways in which the work of the AFD could be expanded or made more effective.

The Education Act (1944), Section 43, envisaged the formation of country colleges and the continuation of part-time education to the age of 18. This would involve either an extension of the School Medical Service to cover these colleges, or, better, a joint appointment for the AFD with the Local Authority so that he would perform the duties of School Medical Officer for the country colleges. In this way the interest of the Local Authority in industry would be extended (103).

The duties of the AFD might be extended to form the basis for an Occupational Health Service that has been suggested:

The best way to improve conditions for all is to ensure that the conditions of work and the mental and physical health of the young is as good as it can be. . . . Health, like peace, is indivisible (103).

If and when there is close cooperation between the family doctor of the handicapped school leaver and the Appointed Factory Doctor

in his place of employment, the general practitioner is in a position to provide much valuable information about the youth's previous medical history. Some principal school medical officers, following a recommendation in a 1954 report from a Committee on General Practice, arranged to send a summary of the school medical history of all school leavers to their family doctors, but after several years' experience the summary came to be regarded by a number of the principal medical officers as a waste of time because such reports merely summarized what the family doctor already knew. It had long been a practice to notify the general practitioner of any defect found by the School Health Service in a school child who was on his list of patients. Therefore in some areas it is now customary to send a summary report to the general practitioner only if it seems likely that he lacks certain information about the youngster (183).

A special Ministry of Labour committee recommended recently a number of changes in the duties of Appointed Factory Doctors and the organization of the service in order to eliminate unnecessary medical examinations, especially of young persons, and to establish a better integrated and more expert medical service with wider duties in the field of occupational health than now exist. The evidence of school medical examinations should be accepted as establishing fitness for employment except when the School Health Service indicates that the youngster has some health defect that renders some kinds of work unsuitable for him on health grounds. Medical examinations of young persons after they have started to work should also be selective rather than routine. Handicapped youth should be encouraged to use the services of the youth employment officer, who should co-operate closely with the Appointed Factory Doctor. Instead of a large number of factory doctors with limited statutory duties, there should be a much smaller number of full-time or part-time doctors with a wider range of responsibilities, as well as more specialized knowledge and experience. The Appointed Factory Doctor service should be available also on a voluntary basis to persons employed in occupations not at present included in safety, health, and welfare legislation (208).

MEDICAL REHABILITATION SERVICES

A variety of medical services is also available to handicapped youth, aside from the School Health Service and the National Health Service, as part of the total rehabilitation program. Distinction should be made between services emphasizing *medical* rehabilitation primarily, as discussed at this point, and those services stressing *industrial* rehabilitation as discussed in connection with vocational assessment and placement (218).

The dimensions of the rehabilitation program in terms of the number of persons served are indicated in a survey sponsored by the

Vocational Rehabilitation Administration. Quoting from this 1963 report:

The British Medical Association estimates that approximately 50,000 persons per year need some form of rehabilitation, and this appears to be a conservative figure. A survey on unselected patients discharged from a general hospital indicated that about 25 per cent needed some form of rehabilitation. Figures provided by the Ministry of Pensions and National Insurance indicated that in 1954 there were 85,000 adult persons who had been incapacitated for work between six months and two years. This figure did not include the chronically ill. During this same year there were 809,000 persons who claimed benefits due to sickness or injury. Of this number 130,000 were in the category of the chronically ill for whom rehabilitation would not ordinarily be considered. Added to this group were 240,000 who had been ill for more than six months. Of the total group, about 144,000 who had been away from work for between six months and two years constituted the group most in need of rehabilitation (386).

Since the medical services in the rehabilitation program are intimately related to other aspects of this program, the purpose and organization of the entire system must be understood in order to see the relationship among the various aspects of the program.

In terms of organization and administrative responsibility, rehabilitation has come to have a technical, though not very precise, meaning distinct from treatment on the one hand and training on the other, although all three (where all are needed) should be regarded as a continuous process. Rehabilitation in this narrower sense serves two purposes—the assessment of capacity and the recovery of basic skill and “tone,” a state that only a few of those discharged from a hospital pass through (286).

The British expression “rehabilitation of the sick and injured” actually connotes

... a continuous indivisible process which, starting from the onset of sickness and injury, comprises all the measures used (1) to prevent undue loss of physical and mental function during illness, (2) to assist convalescent patients to recover full function and to resume their normal way of life without undue delay, and (3) to help those for whom permanent disability is unavoidable to regain the maximum possible physical and mental function, to adapt to their residual disability and to live and work in the conditions best suited to their capacity.

Although it is recognized that there are medical, social, industrial, economic, and other aspects of rehabilitation, it is still considered important that these aspects be regarded as interrelated parts of a single process rather than discrete services, and that therefore the specialists concerned with different aspects should work together as a team (315).

The specialized personnel comprising such a team are provided by many different agencies, both statutory and voluntary. Apart from the health services, the duty of providing for the handicapped is shared among the Ministry of Labour, the National Assistance Board, the Ministry of Pensions, and the local authorities through their departments responsible for welfare services (286).

The sick or injured or otherwise handicapped person can be referred for such services through his family doctor, with or without the intermediate step of hospital service. Where this is needed, it may include medical and surgical treatment; concurrent medical rehabilitation; psychotherapy; an almoner and psychiatric social worker conference; remedial gymnastics; occupational therapy; psychiatric treatment when required; and provision of appliances (218).

Five possible avenues of assistance are available at this point: (1) re-employment in his former job, with rehabilitation within the industry itself; (2) out-patient service in the rehabilitation department of the hospital, followed by help from the employment exchange and the Disablement Resettlement Officer in finding a new job; (3) service from local health and welfare authorities leading to return to his former employer and job; (4) treatment in a residential medical rehabilitation center followed by employment-exchange and DRO help in getting a new job; and (5) assistance, after referral from family doctor or hospital, from the employment exchange and the DRO that may lead to (a) an Industrial Rehabilitation Unit and a new job; (b) an IRU followed by referral to a vocational training center and a new job; (c) training as a severely disabled person followed by a new job in open employment or by sheltered employment; and (d) return home, with possible domiciliary employment (134).

The origin of this comprehensive program can be traced back to the beginning of World War II. The 1941 interim scheme for the Training and Resettlement of Disabled Persons, designed to mobilize all possible manpower for the war effort, represented the first time that the Ministry of Labour arranged, with the consent of Departments responsible for the various types of hospitals, for its officers to get into direct touch with disabled or handicapped persons while they were still in the hospital. Interviews with these persons provided some assessment of their employment needs. The Ministry also introduced a special scheme of vocational training for those who required it, either in the Ministry's own Training Centres, at Technical Col-

leges, or with employers. Such training schemes applied to both able-bodied and disabled persons (134).

In 1943 the Ministry opened the Egham Center for the Industrial Rehabilitation of Men to restore confidence and mental and physical fitness in those coming from hospitals or from medical treatment. Workshops assessed suitability for various occupations, and a resident medical officer supervised the program for each applicant and the progress made in each case.

Also in 1943 was published the Tomlinson Interdepartmental Committee Report on the Rehabilitation and Resettlement of Disabled Persons. Cooperation between the health and industrial services, continuously from hospital to job, was urged, whether the resultant job was in a sheltered workshop or in open employment. Thereupon a joint committee from the ministries of health, education, and labor was appointed to prepare for the introduction of such a scheme as soon as possible after the war.

The first post-war result of the Tomlinson Report was the Disabled Persons (Employment) Act of 1944, with its Registry for Disabled Persons (divided into two sections, the second of which was for more severely disabled persons who normally cannot enter ordinary employment); its Quota of Disabled Persons for industrial establishments; its schemes for sheltered workshops, industrial rehabilitation and vocational training; its National Advisory Council and its local Disablement Advisory Committees and Panels (134).

Voluntary groups have an important role to play in rehabilitation, not only by providing their own rehabilitation centers, but also by bridging the gap between hospital and community. They pass on accredited information concerning special equipment aids for the handicapped to use at home, and on adaptations for the homes of disabled people. The British Red Cross has a large exhibit for indoor display in various parts of the country, and the Central Council for the Disabled maintains a traveling exhibition and information service which tours Britain each summer at the invitation of hospitals, local authorities, and centers of work for the handicapped. Hospitals themselves have been urged by the Ministry of Health to establish resettlement clinics to handle difficult cases, that incorporate many special services. They find voluntary effort still important for after-care; for some material provisions not made by the hospital or statutory body; for transportation to and from work; and for long-term residential provision for the severely handicapped (286).

GENERAL SUMMARY

The medical services for the handicapped school leaver have been summarized and evaluated in the 1963 report of the Working Party of the British Council for Rehabilitation of the Disabled (10). The summary is given in terms of the personnel providing the services.

These services, according to the report, are individually good but they cannot easily provide continuing help during the transition period between school and adult life.

1. The general practitioner or family doctor. In theory he can and should provide continuous medical care and might be the key person through whom the adolescent is kept in touch with services he needs. But in practice the tendency is still to consult the family doctor only when one is ill, and the doctor himself may interpret his role as primarily one of treating sick people. There are also limits to the time and energy he can devote to those whose needs are not acute, and he cannot automatically be expected to have the specialized skill and judgment required for the general oversight of handicapped young people.
2. The hospital physician or surgeon. As the hospital is primarily concerned with the treatment of illness, it helps adolescents only intermittently when crises arise concerning their special disability or illness. Some hospitals transfer the young person, during adolescence, from the children's department to the adult department, occasioning a disruption in the continuity of care for him.
3. The Appointed Factory Doctor. The AFD is concerned chiefly with initial examinations to determine fitness for employment. Both his powers and his opportunities for giving the handicapped continuous care are limited.
4. The industrial medical officer. Though a good industrial medical officer can and does provide good care for the young handicapped worker, he is a stranger to this worker. Also less than 30% of all employed persons work in firms with an adequate industrial health service.
5. The school medical officer. Though this officer, with his associates, gives good supervision during the child's school year, he has no authority to continue that supervision after the child leaves school. Theoretically he might even have official responsibility for the medical care of those receiving further education in local-authority technical colleges, but in practice little medical care is usually provided in such establishments.
6. The mental health service. While this service can and does provide help and supervision for the mentally subnormal, it is not concerned with the ESN youngster during his school days, and it can help only those who seek its aid. Also in practice many "borderline cases" who might be greatly benefited refuse its aid.

In the present situation, then, there is little supervision or opportunity for the continuity in medical care which the handicapped adolescent needs. For various reasons, the School Health Service would be the most appropriate agency to be empowered to provide this continuity of medical care and supervision up to at least the age of 18 (10).

Chapter 7.

Welfare Services

Under the National Assistance Act, 1948, local health authorities have a duty to provide welfare services for persons who are blind, deaf or dumb, permanently and substantially handicapped by illness, injury or congenital deformity, or "mentally disordered." Local authorities are empowered to use voluntary associations as their agents in fulfilling these duties, and to make contributions to their funds. Local authorities are also required to make arrangements for the prevention of mental disorder and the care and after-care of afflicted persons. These arrangements may include residential accommodations such as hostels, or centers for training or occupation. The term "mentally disordered" includes both the mentally ill and the mentally subnormal. For the latter there may be junior training centers for children 5 to 16 years of age, and senior or adult training centers for adults over 16, such centers providing training in good habits of social behavior for those unsuited to normal or special schools. Local authorities must appoint mental welfare officers to look after such cases, and may receive mentally disordered persons into guardianship (28).

HISTORY

In the development of these welfare services, the underlying concepts and the mode of operation of the Elizabethan Poor Law continued with little change into the twentieth century. Disraeli's two nations of the privileged and the underprivileged were paralleled by the two groups of Givers and Receivers. The Administration of relief to victims of air raids during World War II on the basis of the old Poor Law caused much misery and confusion.

However, under the stress of bombardment, and as a result of the drawing together of all members of the community in the face of a common danger, this attitude was profoundly modified and the way prepared for transforming the social services into a nation-wide scheme of mutual assistance and care (93).

Some programs of social insurance against illness and unemployment of workers had existed before World War II, such as provided

in the National Health Insurance Act introduced by Lloyd George in 1911, but these provisions were usually very limited in scope. The programs, administered by a number of different government departments as well as local authorities, lacked coordination. The 1942 Beveridge Report, the Magna Carta of social welfare, surveyed and evaluated national insurance and allied services. As one result the Ministry of National Insurance was created in 1944, which became eight years later the Ministry of Pensions and National Insurance (93).

The war also focused attention on questions of disability in relation to employment, and resulted in the Disabled Persons (Employment) Act, 1948, which like the National Assistance Act gave local authorities the power to use voluntary organizations as their agents. The handicapped person was now regarded as a potential social asset and wage-earner in need of special training and perhaps sheltered workshop conditions, rather than as a social burden. This change in attitude toward the handicapped was also reflected in the activities provided for the unemployable, who instead of doing handicrafts at home were now given the opportunity to earn pocket-money doing routine jobs in a group situation (286).

In order to provide more comprehensive aid — to protect all members of the community from want in all circumstances — social-insurance provisions were supplemented by social-assistance provisions in the National Assistance Act of 1948, "which meant the replacement of the Poor Law and the existing specialised assistance services for the old, the long-term unemployed, the blind and the tuberculous by a unified national scheme of financial assistance to all in need" (93). Up to the time this Act was passed, the social care of the handicapped was left to voluntary groups save for arrangements involved in education for the handicapped. Provisions of the Act are implemented through a National Assistance Board operating through eleven regional offices and 400 area offices, assisted by a number of local advisory committees (93).

Local health authorities now have powers to provide for the welfare of handicapped people by arranging to:

1. inform handicapped persons of the services that are available to them;
2. give them instruction in their own homes or elsewhere in methods of overcoming the effects of their disabilities;
3. provide workshops and, where necessary, hostels where they may live;
4. provide them with suitable work in their own homes or elsewhere;
5. help them to dispose of the produce of their work;

6. provide them with recreational facilities in their own homes or elsewhere;
7. compile and maintain registers for handicapped persons in their own areas.

A local authority may utilize any registered voluntary organization to perform these services, and may contribute to its funds (269). The particular pattern of collaboration between the local health authority and the voluntary society does vary considerably from one area to another (286).

PROVISIONS RELATED TO DIFFERENT DISABILITIES

Of the two-and-a-half million people drawing National Assistance ten years ago, there were about 310,000 children under 16 years of age; 101,000 between 11 and 16; and over 50,000 between 16 and 25 (2). The cost of rehabilitating a handicapped adolescent to the stage where he could be reasonably certain of earning his own living was slightly greater than the cost of further education and technical training for the able-bodied. However, it is estimated that it would have cost ten times more to keep the handicapped youth in idleness for the rest of his life.

The earliest special welfare provisions were those for the blind.

Blindness has always made a special appeal to voluntary effort, possibly because most people find it less difficult to imagine a life without sight than a world without speech or sound, or to comprehend the effects of severe physical disability (206).

The first home visiting services were those for the blind, provided by the Indigent Blind Society in London in 1856. Originally the home visitors read the Bible to the blind and wrote letters for them, but later the home visitor added functions such as teaching the reading of embossed literature. During the early twentieth century a comprehensive service emerged which provided for the certification, registration, and classification of the blind, the education and training of children and young persons through the local education authority, training and employment in workshops or homework programs primarily through voluntary organizations, supplementation of wages, domiciliary financial assistance, hostels for blind workers, homes for the blind, and a broader home visiting or home teaching service. Eventually the National Assistance Act, 1948, empowered local authorities for the first time to provide similar services for the partially sighted.

In addition to those services available to all citizens, some government services are provided specifically for the blind. The National Assistance Board is responsible for financial assistance to the blind,

including blind old-age pensions and supplementary allowances, and provides a special higher standard of assistance for them. The General Post Office provides wireless licenses and special postage rates for embossed literature. The Ministry of Health is responsible for the general welfare of the blind (218).

The local authorities have the welfare responsibilities of examining those claiming to be blind, and certifying and registering those found to be blind; providing home teachers for the blind; helping to place blind persons in open employment; and making general provisions for the welfare of the blind such as providing them with embossed literature, social and handicraft centers, facilities for holidays, diversionary occupations, and all recreational facilities.

Many voluntary organizations provide welfare services, some as agents of the local authorities. They include the Royal National Institute for the Blind, the Guide Dogs for the Blind Association, the National Library for the Blind, the British Wireless for the Blind Fund, and the Jewish Blind Society; they provide services that the local authorities would not ordinarily feel justified in providing. Three advisory and consultative bodies known as Regional Associations coordinate the work of the local authorities and voluntary associations. The work of such associations includes the maintenance of central registers for blind persons, the provisions of training courses for home teachers, and research into certification of blindness. There are two organizations of blind persons, the National League of the Blind (a trade union), and the National Federation of the Blind; there is also one for the deaf-blind, the National Deaf-Blind Helpers' League (218). At present 70% of the local authorities have agency agreements with voluntary societies for the blind and partially sighted, and 17% cooperate with such groups without formal agreements (206).

Among the services provided by the Royal National Institute for the Blind is the production of many special publications. During the year ending March 31, 1965, 498,961 Braille newspapers and periodicals were produced, in addition to 1,655 volumes of music, 33,160 volumes of literature, 67,503 music and literature pamphlets, and 72,240 special supplements to periodicals—a total of 673,519 pieces of embossed material. The range of magazines includes those concerned with the tastes of music lovers, Girl Guides and Boy Scouts, physical therapists, chess players, and many others, while in the technical field there are materials of interest to theologians, tape recorder enthusiasts, piano tuners, and lawyers. For those who find the small Braille dots difficult to decipher, the Moon printing works produced a total of 46,500 books, periodicals, and pamphlets during the year, which was 25% higher than for the previous year. Not all the embossed books are mechanically printed. In the same year volunteer transcribers added 1,058 new volumes to the shelves of the institute. During that year 17,015 volumes were issued on request.

There was also an expansion of Tape Talking Book Library, with a continued change-over from the long-established disk system. Some 340,000 recorded books were issued to members, and the number of titles available reached a total of 850 (335).

The deaf-blind have specialized needs which require additional services. The two main groups are (1) those with a "deaf mentality," who were born deaf or became deaf in infancy, and (2) those with a "hearing mentality," who became deaf later in life. Each category may be further subdivided into those with a recognizable degree of fair or good intelligence, and those with what appears to be intelligence of a poor quality. The term "intelligence" refers to the capacity to cope with everyday life and the ability to communicate successfully. The grouping together of those of similar intelligence levels is found to be the best arrangement for them. Their homes need to be small, and should provide single bed-sitting-rooms if possible, with any special equipment and safeguards that may be dictated by their disabilities. They also need the sense of liberty and independence which excursions with "voluntary friends" can give them, and the local social stimulation of club activity (199). These needs are often met by agencies such as the Missions for the Deaf, the National Institute for the Deaf, and the National Deaf-Blind Helpers League organized by the deaf-blind themselves (323).

The deaf are more numerous than the blind, but most people find it more difficult to grasp the full significance of deafness in its various forms, and to understand the adjustment problems faced by persons with this handicap.

Lack of understanding and insight may be the reason why the deaf have been so long neglected in British legislation, and why the handicap itself fails to arouse the same compassion in the public mind as other disablement does. Thus while in the period 1918-39 five Government Reports on different aspects of blindness were published, only two appeared on deafness (403).

Welfare services for the deaf have therefore developed more slowly.

Dr. Johnson described deafness as the most desperate of human calamities and those with personal knowledge and understanding of the effects of total deafness, whether from birth or later, might find it hard to improve on this description. It is difficult, too, for those with normal hearing to imagine a world with no bird song and no music—even no motor horns—or to conceive the frustration of the mother who cannot hear her baby cry, or the kettle boil. It is hard to understand that without language there can be no concepts, and thought itself is limited (206).

Up till 1948 welfare work for the deaf was done almost entirely by voluntary groups coordinated by the Royal National Institute for the Deaf. These voluntary societies and missions for the deaf were originally staffed by "missioners," usually ordained clergy, because of the early religious basis of this work, though as the work expanded to include employment and social and recreational facilities, lay officers began to be employed. In the early years these workers learned on the job, but in 1929 a Joint Examination Board, later known as the Deaf Welfare Examination Board, was established by the voluntary organizations to select and examine candidates for the diploma or certificate of the Board. The National Assistance Act, 1948, enabled local authorities to provide services for the deaf and hard of hearing, either directly or through agency agreements with voluntary groups. In 1950, 92% of the local authorities in England and Wales provided services for the deaf through formal agreements with voluntary groups, and 27% also cooperated with one or more missions or deaf institutes without the formality of an agency agreement. In contrast, few authorities have agency agreements with organizations for the hard of hearing, such as the British Association of the Hard of Hearing (206).

Each deaf school leaver has a report and recommendation concerning his future sent to the local Youth Employment Office and to the local welfare society for the deaf, which assists the deaf at all times in their social, religious, and industrial life. These voluntary societies are staffed by fully qualified interpreters and welfare workers who can communicate with all categories of deaf people. The societies work in close cooperation with the Youth Employment Offices, Employment Exchanges, and local health authorities which are providing welfare services for the "deaf and dumb," and acts as agents for many of the local authorities.

Hearing aids are available to all who need them and are maintained free of charge for the patient. They are provided where necessary after examination and tests at special clinics attached to certain hospitals to which the patient is referred by his own doctor (218).

Local authorities register the deaf in two categories—the deaf with speech and the deaf without speech. Since the new records show that the first group represents a substantial number on the register, new types of welfare service are being developed for them, along with an expansion of the traditional services for those without speech. New social centers for the deaf and hard of hearing, built specifically for this purpose, have been established in Bristol and Luton by voluntary groups, and in 1962 a residential training center was opened for maladjusted deaf youth and young men, the first of its kind in the country (200).

Most of the welfare work for the deaf is performed by the voluntary Missions for the Deaf. About 90 of these Missions cover areas that do not quite coincide with local government district lines. The Royal Association in Aid of the Deaf & Dumb, the largest, includes most of London and the Home Counties, with 18 separate centers. These Missions were founded principally by Church of England workers for religious and charitable work with the deaf in industrial areas. In the last hundred years they have expanded to cover the entire country and include all religious denominations. Their range of services now goes far beyond the original spiritual welfare work; they interpret the world to the deaf and the deaf to the world. Qualified welfare officers for the deaf must hold the Diploma or the Certificate of the Deaf Welfare Examination Board. Board members are appointed by the Royal National Institute for the Deaf and the Church of England Council for the Deaf. The examination covers spiritual instruction and the theoretical and practical aspects of the missions' work. Diplomas are awarded for taking both parts of the examination, and certificates for the second part only. Candidates must have had three years of in-service training under a qualified welfare officer (200).

The missionary or social worker has an important role in interpreting for the deaf, that is, acting as a buffer between the deaf and the hearing world (403). In summary, welfare officers for the deaf undertake home visiting, attend social centers for the deaf, provide interpretation when necessary, and help to ease tensions and the misunderstanding which frequently arise between the deaf and their relatives, employers, friends, and neighbors (206).

The Royal National Institute for the Deaf has attempted to upgrade the profession of the welfare officer for the deaf by recommending a more professional type of training for this officer. The Institute's Recruitment and Training Committee, in cooperation with the Deaf Welfare Examination Board, has recommended that a central residential college for training in welfare work for the deaf be established, preferably at a suitable place near London, this college to be known as "The British College for Welfare Workers for the Deaf." Training would be provided for about 30 persons. Qualifications would specify two years of basic training at the National College of Social Work Training, to be followed by a further 18-months training at this new college, to include both practical and theoretical work. Upon completion of this period of training, there would be a 12-months probationary period before a welfare worker for the deaf would be recognized as being fully qualified (289).

Some believe that the social clubs provided for the deaf do not meet often enough and are frequently poorly equipped. A closer liaison is needed between clubs for the deaf and for normal youth in order to assure better facilities for young deaf people (90), and to

make possible greater mutual understanding. There is still need, however, for clubs exclusively for the deaf because of the relaxation they find in being with friends with similar problems. Depending on their degree of hearing loss, deaf youngsters sometimes join a hard-of-hearing club; there are 150 of these in the United Kingdom, the British Association of the Hard of Hearing acting as a liaison body. Although these clubs are mainly social centers, many also have lip-reading classes under qualified teachers of the deaf, sometimes arranged in conjunction with the local education authority (49).

There are 17 homes or hostels which meet the varying needs of the deaf of all ages who require specialized care which cannot be provided in other institutions. Six of them are run by the National Institute for the Deaf, seven by local societies or Missions, one by a County Borough, one by the British Deaf & Dumb Association, and two are independent. The residents are usually referred by local authorities. The British Deaf & Dumb Association, organized by the deaf themselves, operates summer schools which provide its members with holidays plus vocational training (49).

A more positive attitude toward the deaf and hard-of-hearing and their capacities is shown by the official change of the term "partially deaf" to "partially hearing," and by the change of title of the publication of the Royal National Institute for the Deaf from "The Silent World" to "Hearing."

Some of the more severely handicapped who are "on the borderline of educability and employability" (10) are cared for in Dr. Barnardo's Homes. Of the 187 children who left the Homes in the period from 1953 to 1960, 76 were immobile, 74 were unable to cope for themselves, 82 were incontinent, 77 probably unemployable, and 22 severely mentally handicapped. The Homes perform three major tasks: (1) to provide Homes and a sense of security for the children; (2) to make an early study of possible medical, surgical, or therapeutic treatment of the child's disabilities, in consultation with appropriate specialists, the parents, and local authorities; and (3) to integrate school and home so that educational progress can be made when the child is emotionally and physically ready to benefit from it. Regular case conferences are attended by the Homes' chief officer, the educational advisor from headquarters, the superintendent, the head teacher, physiotherapists, speech therapists, representatives of the nursing and child care staff, the youth employment officer, and a representative of the children's department and the local education authority concerned with any child if they wish to attend. Of those leaving the Homes, a considerable proportion are immobile and not suitable for training either for open or sheltered employment. The effective use of the hands is all-important for them, since it would enable them to enjoy some handicraft or hobby or to develop a skill which could bring in a little pocket-money (10).

The growth of social care has been particularly evident in the case of those with tuberculosis. The social implications of this disease, which was first required to be reported in 1912, have long been recognized. Awareness of its relation to overcrowding, poor housing, malnutrition, and squalor paralleled by economic difficulties and disrupted family life stimulated the concurrent development of social and medical care, with care committees and after-care arrangements becoming part of the welfare services (206). The increase in incidence during World War II led to further efforts to improve facilities for medical diagnosis and treatment, and also to the payment of allowances to encourage those with certain forms of the disease to undergo treatment. After the war, local authorities were asked, when organizing programs under the National Health Service Acts, to judge to what extent existing care committees could undertake after-care work; these committees were to cooperate with existing medical, health visiting, and social services, but to avoid any duplication of services. Central to these services is the almoner. The first almoners employed in local government service were appointed to the tuberculosis service, where most of them are still employed. Also important is the health visitor, a public health nurse with some special training in maternal and child welfare, who educates patients and their families concerning the nature of the disease, the management of the patient at home, and the prevention of infection. She also traces contacts, persuades them to be examined, and oversees the arrangements for care. She reports on the home circumstances of new patients and in-patients ready for discharge, and is closely associated with the chest physician so that she can be briefed on the clinical aspects of care. In other words, she is the "practical social worker" in the home. In most cases no actual nursing work is done (122).

The 2,000 hemophiliac boys and men in England and Wales are assisted by the Haemophilia Society, which recognizes that apart from the physical problems caused by hemophilia, there is the psychological problem of loneliness and isolation which seems to affect most sufferers, perhaps because of the relative rarity of the complaint. Therefore one of the chief purposes of the organization is to provide a center of interest for hemophiliacs, to supply them with needed information, advice, and special services. Help in solving their problems can be supplied both to the persons afflicted and their families, and also to the other agencies concerned with their welfare. Among the many services provided by the Society, arrangements are made for supplying hemophiliacs with electric razors at wholesale prices, since other kinds of razors are hazardous (92).

Information about the management of hemophilia is given in pamphlets issued by the Ministry of Health in conjunction with the 32 Haemophilia Reference Centres established by the Medical Research Council in England, Scotland, and Northern Ireland. Each

hemophiliac, when examined at one of these centers, is furnished a green Haemophilia Card to be given a doctor or dentist dealing with an emergency (280). Through each Reference Centre arrangements can be made for schooling, home teaching, and training for and finding suitable jobs.

There are ten epileptic colonies and homes for adults, with places for about 3,000 men and women. With the exception of two colonies previously provided by the London County Council and now under a Regional Hospital Board, one operated by the Manchester City Council, one by the Surrey County Council, and one by the Leeds City Council, all the colonies belong to voluntary organizations which receive some financial assistance from the local health authority. Epileptic colonies date from the early part of the century when treatment was much less effective and when the object was to provide a home and occupation for people who might return eventually to the community but who were not expected to do so (218).

Some improvements are needed in these colonies. They should select patients more carefully. The patient's major disability should be carefully determined as a basis for deciding whether to place him in an epileptic colony or hospital, a mental or mental-deficiency hospital, or a hospital for the chronically ill. Purely custodial care may be emphasized at the expense of true rehabilitation and opportunities for employment. Colony residents are given occupation but no actual preparation for work outside the institution. They help to maintain the premises and its farms and gardens, but are given no specific trade training. Fortunately modern methods of medical diagnosis and treatment are reducing the number who need colony provision (203, 218). Administrative changes have been urged to provide closer links with the National Health Service (203).

An example of a more modern approach is that of an epilepsy clinic designed as a community service. St. John's London County Council Hospital Epileptic Clinic was opened in 1946 to give continuing assistance to epileptic patients discharged from London County Council mental hospitals. These persons needed prolonged after-care and sometimes special help in times of crisis. Intimate knowledge of the patient and his family, of his home circumstances and community setting, have made possible effective medical social work. Psychiatric therapy and psychological testing are provided. Patients are referred back to their private doctors when the seizures have been stabilized, work has been found, and social problems have been met. Patient and relatives are encouraged to return for advice and further help. The largest group of patients has been in the age range 20 to 30, with men outnumbering women two to one (160).

The Piercy Report and Ministry of Health circulars to the local authority have stimulated the development of the following kinds of welfare service:

1. provision of social centers or clubs operating on a full-time or part-time basis, transportation being provided in some instances.
2. provision of home instruction through the services of domiciliary occupational therapists.
3. taking the severely handicapped into local authority homes for short periods to relieve relatives (269).

Such services aim to provide the handicapped with more normal social activities and identification with the community. Clubs for the disabled are one of the chief activities of the older voluntary organizations. These clubs have continuing membership and regular meetings, generally in a church hall or a similar building, with a program usually consisting of a talk, group singing, and a cup of tea. The aging membership is in some cases a problem, and there may be difficulty in providing adequately for the interests of younger persons. The club with a purpose is tending to replace the purely social club for the younger people, and they indicate more desire to plan their own activities (286). As a result, attendance at these clubs may actually provide the opportunity for continuing assessment of the potentialities of the handicapped youth, so that in some cases such attendance may be the first step in the direction of training and eventual remunerative employment (10).

An example of special clubs for the disabled is the 62 Club for the cerebral palsied originated in London by the Spastics Society. This club is run as much as possible by the cerebral palsied themselves. Meeting in a basement room of the Society building, an average of 40 attend meetings, coming from all parts of the London area. Similar clubs have been started at Nottingham and Cardiff. Many young people also belong to clubs affiliated with local groups of the Spastics Society, but these are *parent* organized, whereas the 62 Clubs are organized by the groups themselves. Member ages are school-leaver age on; the clubs give them a chance to meet in a mixed group.

In addition to clubs, voluntary associations organize excursions, trips, and parties. Members visit homes to give help and advice when needed. Clubs, classes, and centers are usually open to all handicapped people rather than to a single category of handicap. There are also many local societies with special aims such as the Swimming Club of the Plymouth Council of Social Service, which has a membership of about 50 disabled young persons. The blind, the deaf, and the hard-of-hearing usually meet in separate groups, however, with activities planned to meet their special needs.

In 1964 various Essex organizations provided holidays for over 1,000 handicapped persons. Holiday camps are taken for a week at the beginning and end of the season in May and September in coun-

ties such as Kent and Norfolk. The services depend for their success on the recruitment of men and women who will give voluntary help as nursing aids, or who will drive and lift and push. The British Red Cross Society is especially active in this work. The holidays arranged have been so successful that now there is a far greater demand than can be satisfied (145).

The British Polio Fellowship maintains two hotels for holiday purposes, one on the south coast at Worthing for 26 persons, and the other in the northwest at Lytham St. Anne's for 28 persons. They also opened recently a specially designed and equipped prefabricated bungalow for family holidays at Burnham-on-Sea (281). These places serve polio victims on a year-round basis, plus some other types of disabled persons in the off-season. Persons come from all parts of the country, and usually stay a fortnight; they can come with their family, since these are family hotels. At trailer camps caravans (22-foot trailers) have a fixed installation; six of these, situated in various parts of the country, are available for holidays also on a family basis, each accommodating 4 to 6 persons. Though these cost 6, 7, or 8 guineas a week according to the season, some form of subsidy is available. The British Polio Fellowship also organizes an annual swimming meet for persons who have had polio; in 1962 a competition of this kind was conducted in Birmingham on an elimination basis, with between 150 and 200 competitors from various districts who devised their own rules and handicapped conditions.

Social and recreational needs are also met by providing modestly paid occupation in a group setting. As a general rule, the benefits of occupational therapy are enhanced if the products provide some income (226). Some voluntary groups are establishing "work centres," at times in combination with a homework program. Handicraft or simple assembly work is made available, perhaps for half a day five days a week. The work is similar to some hand processes in factory mass production, and is more satisfying than craft work for some because it seems more meaningful. Workers are permitted to earn one pound a week to supplement the National Assistance allowance or sickness benefit. It may be a problem to find suitable and regular work, depending in part on the industrial development of the area. In general, the provision of regular occupation for gravely crippled young people is quite inadequate (10). Even the voluntary groups attempting some provision of this kind admit that "they are barely scratching the surface of the problem" (286). The severely handicapped person is most concerned with being able to do useful work; financial incentive is secondary. Work under sub-contracts is undertaken at a pace suited to the individual. Experience thus acquired in the discipline of working life enables some persons to undertake training and eventually to move on into sheltered workshops or open

industry. Even where local health authorities have established these social and occupational centers the premises are often unsuitable. There is a need to establish more, and more adequate, centers, which is often difficult in sparsely populated areas especially when the numbers needing the service are few and travel is inconvenient. Sometimes cooperation between the local authority and a voluntary society may make possible the establishment of a center, as in the case of the local authority at Swansea which in collaboration with the local branch of the Spastics Society provided a center in which a number of diversionary occupations were made available to spastic school leavers who had been difficult to place in employment, further education, or training (286).

Work centers would probably be attended by more handicapped youth if National Assistance regulations were changed, which require earnings exceeding a pound a week to be deducted. The raising of this limit would be more realistic, and offer greater incentive for young people to participate in the program of the work center (286).

The general problem of providing suitable living quarters for the young disabled, without housing them with the aging, has been acute. Many handicapped young people are in the chronic wards of hospitals and mental deficiency establishments or in schools and homes for the backward and maladjusted simply because there is nowhere else for them to go; many of these are receiving little or no help in preparation for a useful occupation as adults. A number are receiving occupational therapy in these settings, but occupational therapy, while an important part of rehabilitation, does not prepare youth for wage-earning jobs, and if the youth receives nothing more than this, his determination to overcome his disability may be lost (95).

The provision of aids to living and adaptations to homes has enabled many severely handicapped persons to remain with their families in their own homes. Adaptations and special equipment have been provided by both voluntary groups and local welfare authorities, and the handicapped themselves often show ingenuity in devising special aids. Earlier determination of the living and housing aids needed when he leaves school may make it possible for the handicapped pupil to return home rather than to enter an institution. The home visits of the local welfare officer when the youth returns are also important, since adjustment to life at home is often not merely a matter of physical adaptation but also one of emotional adjustment.

For the many chronic cases that are nursed at home, home helps may be provided by local health authorities. For example, the mother of a youngster with muscular dystrophy may have an exhausting round-the-clock program of care, sometimes turning the youngster in bed several times during the night to prevent cramp. For this family not only home-help aid is necessary but also opportunities for

holidays for the child, occasional short periods away from home for him in accommodations for the chronically ill, and grants for sick-bed amenities (229).

Many examples can be given of the special living arrangements made for severely handicapped youth. In the Dorincourt Estates established in 1953 jointly by the National Association for the Paralyzed and Queen Elizabeth's Training College for the Disabled, there is a residential sheltered workshop for very severely disabled men and women. The young patients are helped in a variety of ways—by assessment and advice, by remedial treatment on a broad basis, by sheltered employment in congenial surroundings with others of similar age, and by a large number of recuperative holidays (69). The City of Norwich has a hostel with 30 places cooperatively provided by the neighboring authorities of Norfolk, Suffolk, and Cambridgeshire who share the places available, 16 being reserved for Norwich (286). The City of Leeds has a hostel where accommodations for epileptics are shared with 14 adjacent authorities.

The National Association for Mental Health provides three school-leaver hostels: one for adolescent boys and another for adolescent girls who have attended ESN special schools, and who need help in adjusting to adult life, and a third for twelve maladjusted boys from Shaftsbury House School. The Association has a social worker who selects and advises landladies willing to take maladjusted adolescent girls. These girls might be unmarried mothers with a child, girls from a women's prison, girls from a hostel for maladjusted girls, and girls from an "approved school." Foster homes provide more chance for adjustment to normal life.*

The welfare services have responsibility for school leavers judged incapable of employment. Therefore the local health authority makes a grant which, with National Assistance, is sufficient to meet the fee charged if they are placed in a residential center. The number of places is not adequate to meet these needs. Many young persons return home from special residential schools, or stay at home after leaving day schools, without occupation, and inevitably deteriorate. Occupation centers, where they exist, provide for a proportion of the mentally backward, but there is no comparable provision for the physically handicapped. Voluntary effort fills some of this need by providing suitable residential care and by organizing activities for those who return home and for whom local authorities make little or no provision (286). A 1963 government report indicated that only 11 new homes, providing 322 places for the younger handicapped persons, were proposed in local-authority plans. Since the number who need residential accommodation in any one area is small, joint studies by groups of local authorities in consultation with voluntary groups are needed to determine what further provi-

* Interview with Miss Appleby, National Association for Mental Health, July 1963.

sion should be made. There is also a shortage of suitable accommodation for people with certain multiple handicaps such as blindness and deafness (200). It has been recommended that local authorities and voluntary organizations establish a list of residents willing to accept blind or deaf-blind workers into their homes as lodgers in communities where workshops for the blind are located (199).

Voluntary provision for the young disabled takes so many different forms that classification is almost impossible. Some homes take only those who are incapable of work; others provide sheltered employment (not always under the Ministry of Labour's scheme); others again have workshops keeping regular hours where earnings are limited to the one pound a week allowed to those on National Assistance Board grants; still others teach a variety of handicrafts to those capable of following them and sell the products for them without making this a condition of acceptance; some "diversionary" activities are a feature of nearly all homes which have no regular work scheme. Some homes take both the chairbound and the ambulant, and long-stay homes often accept a few of those needing a recuperative holiday when they have beds available.

Special attention is increasingly given to the overall design and equipment of the accommodations for handicapped persons. Houses specially designed for the handicapped have been built by a number of local authorities and voluntary organizations. The Harrow Council, for example, has three bungalows for disabled people to meet the demands of anyone confined to a wheelchair, a project representing collaboration between the Middlesex County Council and the British Polio Fellowship.

Local authorities also may assist handicapped people in meeting the cost of adaptations in their homes, such as ramps, wide doorways, ground-floor lavatories, guide rails, grips, and special switches, taps, and door-handles, besides lifting apparatus, built-in or portable, by which a handicapped person can be lifted or can lift himself. Many ingenious devices are provided by local authorities and voluntary groups to help with everyday activities such as dressing, cooking, feeding, and housework (200). One electrical mechanism, by means of the operator's lightly sucking or blowing through a tube, controls the ringing of a bell, the switching on or off of a light, the dialing of a telephone, and the use of a typewriter (121). Both the blind and the deaf-blind need special safety devices such as gated stairways, roped walks, specially adapted fire escapes, and guarded open fires (199). The handicapped who have been previously hospitalized are prepared for adjustment to these special arrangements by rehabilitation services within the hospitals, which in some instances have a program for adjustment to daily living with model kitchens or even entire homes, and which maintain demonstration exhibits of the aids and devices used (386).

The Royal National Institute for the Blind keeps lists, including prices, of various forms of equipment and games for the blind. The Royal National Institute for the Deaf publishes "Special Aids to Hearing" which describes a special hearing-aid telephone, radio and television adaptors, light-flashing doorbells, a baby alarm for deaf parents, and a light-flashing alarm clock (331). The Central Council for the Disabled has prepared an exhibit of a model home for the handicapped, equipped with every kind of aid for daily living (22, 23, 26).

A special committee on mobility for the disabled, representing 16 organizations including the Invalid Tricycle Association, recommended to the Ministry of Health that disabled National Health Service patients be supplied with a small car by the government instead of an invalid tricycle. The government agreed to provide these small cars for disabled war pensioners, and from 1960 to 1963 approximately 2,000 were issued. The committee urged that this service be extended to all the disabled. Cars are preferable to tricycles because the disabled person has to ride alone in an invalid tricycle, and cannot take his family with him. Also the tricycle needs constant attention and has a total mileage life of only 35,000 miles; its shorter life as compared with a regular car offsets the difference in price (30).

Welfare authorities issue badges to identify vehicles of severely disabled drivers. This arrangement helps disabled drivers by easing their parking problems, gaining concessions from traffic authorities in the use of parking places and meters as well as the sympathetic assistance of the police (286).

When the handicapped marry, they may need help in finding both suitable housing and house help. For example, it may take a cerebral palsied mother as long as 2½ hours just to bathe the baby, who would be getting hungry and restless meanwhile. Workshops for the husband are needed in the same building where special flats are provided. Some cerebral palsied young people are content to satisfy their needs for status or a sense of belonging to someone else by remaining on the engaged level. It is estimated that adequate provisions to meet special housing needs would cost half a million pounds over a ten-year period.*

The British Diabetic Association gives advice to diabetic school leavers who plan to marry in a quarterly called "Balance." Topics discussed in one issue included "Marriage and Diabetes," "Diabetes and Pregnancy," "The Ideal Kitchen," "First Dinner Party," "A Home of Your Own," "Members' Recipes and Cookery Hints," and "The Honeymoon—Where to Go" (6).

Handicapped persons like the population in general can get information and advice not involving serious personal or social problems

* Interview with Mrs. C. Clifton, Spastics Society, July 1963.

from free citizens' advice bureaus in population centers all over the country. Local committees and bureaus are autonomus, but the National Council of Social Service advises and assists them (93). People consult the bureaus for advice concerning mental illness or subnormality; some are referred by doctors, psychiatric social workers, or almoners for the solution of everyday problems (68). Many persons still feel there is some stigma attached to such conditions, and would refuse to seek help from an agency for the mentally ill or subnormal. It is believed that the bureaus can make a special contribution in the community in relation to the problems of the 15-to-20 age group, as indicated by records being kept of inquiries concerning such problems.

A number of bureaux are organizing special sessions for younger people, and many are taking steps to make known through the youth organizations in their town their willingness to see and advise them (255).

Problem families are recipients of welfare services. They are a comparatively new phenomenon, so far as social awareness is concerned (206). The earlier profusion of moral condemnation of inadequate families is now being replaced with "action" research through carefully recorded long-term work with a small number of families. Results indicate that the families included in the general term "problem families" cover a wide range of characteristics and problems, including a heavy concentration of mental retardation, emotional immaturity, inadequate personality development, and lack of sense of social obligation.

The Wood Committee report in 1929 discussed the "social problem" group as one which contained many defectives, paupers, criminals, and other social undesirables. At that time the problem family was thought of as one containing persons with hereditary deficiencies and abnormalities. Now it is defined as one with a multiplicity of social, personal, and financial problems plus an inability to use the social services available to help them. Five commonly recognized features are (1) mental subnormality, (2) temperamental instability, (3) ineducability, (4) a squalid home, and (5) the presence of numerous children. The first two may be considered causal, though many mentally subnormal persons lead socially useful lives. Educative work with such families is primarily the task of the health visitor (including the school health visitors). This educative approach complements the casework approach of the social worker. Some problem families, however, suffer from too much attention and too many visits from different officials and social workers (93).

Problem families do not automatically contain mentally subnormal members, though mental deficiency continues to be a major concern of the welfare services. The educationally subnormal child comes under the Department of Education and Science, but the "mentally

subnormal" child of lower potential is the responsibility of the Ministry of Health through its welfare provisions. This division of responsibility is being questioned as fostering unrealistic distinctions between the needs of the ESN and the mentally subnormal child. A realignment of responsibility may bring closer integration of provisions for the ESN and the mentally subnormal.

Experts recognize that many welfare needs for handicapped youth are still not met satisfactorily. The problem of obtaining residential accommodation with full-time care is most acute for children with muscular dystrophy. An increasing number survive now into their late teens or early twenties because of medical advances in the treatment of the chest condition which ultimately causes death. Since the disease is progressive, they may require care not possible in the home. Frequently the only places available are not suitable, such as the chronic wards of hospitals for the severely handicapped which provide few or no facilities for occupation of any kind. There is an urgent need for homes specifically for young people suffering from muscular dystrophy and other severe physical handicaps.

When the severely handicapped youngster remains in the home, parents sometimes need help in caring for him which is not available, as indicated in a report on 21 children with cerebral palsy and mental handicap in the Sheffield area :

It should be noted that only two of the children in this group had been given holidays away from their families. Since over half the children in the group were for all practical purposes unable to walk alone, they presented a heavy and trying management problem; the burden fell largely on the mothers, who frequently showed evidence that they would have benefited from a short rest from these responsibilities. In this group the mental health workers seemed to have failed in several instances to establish a helpful liaison with the parents. Several of the children were reaching a stage when they could no longer be managed at home. No one seemed to have anticipated this situation and in no case was the child's name on a waiting list for institutional care. Thus when these parents reach the point of exhaustion they will have to face a waiting period of up to five years before a vacancy occurs in an institution (96).

Parents often do not know about the kinds of services that are available, but even when services are used, problems may still arise for parents. For example, the assessment of a cerebral palsied child may involve a number of tests necessitating numerous visits which place a considerable strain on both children and parents, and this strain may affect the children's performance unfavorably. Even when ambulance transportation is offered to children who find it difficult to travel in public transportation, parents sometimes refuse

or later give up this service because of the amount of time involved in taking the child for physiotherapy, speech therapy, occupational therapy, and orthoptic treatment. The time required for such trips leads to disorganization in the household, especially if there are other children, so that in some cases the benefit gained by the handicapped child may be outweighed by the strain placed on the parents. Parents need a specific person to whom they feel free to go for advice about social and management problems. They usually feel they cannot discuss their problems in a busy orthopedic out-patient department, with its emphasis on the medical treatment of the child. Physicians frequently confine their attention to the medical examination or treatment of the child and do not explore the fears, anxieties, and difficulties of the parents. Even where attempts are made to meet the needs of both parent and child, such efforts are usually uncoordinated. No one worker may consider himself responsible for explaining the nature of the handicap to the parents in a way that is appropriate to their intelligence and outlook. As a result many parents do not receive help in anticipating and planning for the future problems presented by their child's handicap. A too large case-load may prevent giving the desired help. The hospital may not notify the local authority immediately after a handicap is diagnosed, and so there is unnecessary delay in establishing a liaison between the child and his parents on the one hand, and the local authority and the services it offers on the other. Even in the hospitals themselves, the child may not be referred to the almoner's department, and when he is referred, the shortage of staff may make it impossible to give adequate consultation and follow-up services. It has been recommended that a doctor be appointed, who has a keen interest in the social aspects of medicine, to work with the almoners and health visitors and assume responsibility for diagnosis and treatment (96).

Lack of continuity in care is a problem in the case of children who, after a period in the ordinary school, are ascertained as unsuitable for education at school, and then transferred from the jurisdiction of the education authority to the jurisdiction of the health authority. The difficulties and trauma experienced by the parents when the ascertainment occurs would be reduced if the children remained in the care of the education department, but instead they are transferred to completely unfamiliar persons in the health department just when the parents are most in need of the support of familiar workers who are well acquainted with the domestic background and the personalities of parents and child (96).

The severely handicapped youngster who does attend school, but who needs welfare provisions after leaving school, may suffer from a lack of close liaison between the special school and the welfare workers who are important in his post-school social adjustments. This has sometimes been true in the case of deaf school leavers,

when the welfare workers have not worked closely with the schools, and have not given help with the family problems of the deaf before the youngster actually leaves school. Such a broadening of the organization of welfare work requires a new orientation in the training of welfare workers (96).

A goal of increasing importance is the fuller incorporation of the parents into the treatment program by discussing with them at every stage what is being done for the child or what should be done. For there is danger that parents may be overwhelmed by the official personnel, and made to feel so unimportant or inexperienced that they lose their sense of intimate responsibility for the child.

The pressure of organized services is such that it is only too easy for the parent's responsibility to be diminished and to be succeeded by the benevolent impersonality of the social institution (96).

Better coordination among the public and voluntary welfare services provided the handicapped youth could avoid needless duplication of services and lead to a selective reduction in the number of interviews, examinations, and humiliations to which such an adolescent may be subjected (2). This coordination might be achieved by having the local welfare officer remain responsible for the same individual throughout his lifetime.

One of the most important developments in the field of welfare services has been the emergence and gradual recognition of the various social work professions in England, along with emphasis on special training for their work (93). Victorian social workers were inclined to be didactic and moralistic in their approach, but the social worker today tries to discover the reasons for her client's behavior rather than to assess his moral responsibility. Charity organizations thus changed their attitudes toward the people they helped, with resultant changes in principles and practices designed to meet the needs of different categories of people in different institutional settings. As professional training was developed, it was finally incorporated into the principal statutory social services, although statutory and voluntary agencies continued to cooperate in the provision of social case-work (93). An example is that of the Invalid Children's Aid Association, founded in 1888 as an offshoot of the Charity Organisation Society; one of its services continues to be social case-work with crippled and invalid children, filling in gaps which local authorities are not able to provide (129).

Social work preparation became a more integral part of university offerings, though the social worker was not brought in to deal with family problems to any extent, except in a field like delinquency, until the time of the Second World War. Initially various agencies had their own social workers trained for their own special purposes, but it was increasingly recognized that social workers needed a

broader type of training, especially in working with handicapped persons and their families (93). Different types of training are justified, not on an agency basis, but on the basis of broader distinctions in role indicated by the titles of almoner, psychiatric social worker, health visitor, and welfare officer (206). The professionalization of social work has been facilitated by increasing cooperation among groups representing these various types of social work (123).

An interesting comparison between the situation regarding social workers in England and in the U. S. was made recently by Sir Charles Morris, chairman of the Council for the Training of Health Visitors and of the Council for Training in Social Work in the annual meeting of the Institute of Almoners in London in March, 1964. He stated that "In England we select, but do not train; elsewhere they train but do not select" (103).

The role of the social worker, in serving handicapped youth like people of other ages, is to aid them in their social and emotional adjustments, which may be more disabling than the basic handicap itself. Does the youth find it difficult to relax and accept medical or therapeutic treatment because he is ashamed to "have anything wrong with him"? Or is he an immature and neurotic person who welcomes illness and the dependency it brings? Does he use illness or disability as a means of controlling and forcing his will upon his relatives? Does he cling to his disability as a refuge from a world that seems hostile and unsympathetic? Does he feel diminished, as a person, by his disability? Does he judge himself too literally in terms of an ideal of perfect health or perfect physique? Some social workers believe that too much emphasis can be placed on perfect health instead of accepting realistically the fact that some illnesses cannot be cured, and some disabilities cannot be removed; that the years necessarily bring with them some health problems and diminution of function (222).

Welfare services for both the handicapped and able-bodied represent a collaboration between public and voluntary agencies, the latter having played an important role in initiating and expanding these services. Social services in England today are regarded as both an expression of the ideal of greater social equality, and a means for bringing about this equality. Welfare as a term has come to be interpreted in a broader sense than that of physical well-being, for it now includes economic and moral and psychological welfare. One writer has summarized these developments as follows:

The more important modern developments in social service and the social services which have led up to the situation today are then, the increasingly active and prominent part played by the State, which has gradually assumed responsibility for meeting the basic needs of all its citizens; the widening of the scope of the social services to include the whole

community, without distinction of social or economic class; the acceptance of the benefits they confer as rights; the increasing importance attached to the adjustment of relationships as well as of meeting material needs; the increased and increasing influence of the scientific attitude and the development of social research, and the growth of professionalism (93).

CHILDREN IN CARE

Handicapped children are eligible for welfare services for children called provisions for "Children in Care" in England. The two main forms of permanent care available for the deprived child are boarding out and institutional care, the former being preferred generally (93). Sometimes, however, the needs of the youngster are best met in an institutional setting; this is perhaps the case with an adolescent who feels that living with foster parents threatens his allegiance to his own family ties. Handicapped children are also being placed today in foster homes. Public authorities and voluntary societies are both aware of the child's need to maintain contact with his own family when he is in care, through letters, visits, and holidays (65).

Two landmarks in the history of child protection were the Children Act, 1908, and the Children and Young Persons Act, 1933. The latter, amended in 1952, provides for prosecuting and sentencing those willfully neglecting or cruelly mistreating a child, and gives juvenile court magistrates the power to remove children or youth from the custody of their parents or guardian when necessary. Cases can be brought to the court by the NSPCC, the various departments of the local authority, and the police. Improved administrative procedures were incorporated into the Children Act, 1948 (93). This Act also required each local health authority to appoint a child care officer.

There are no specific educational qualifications required for appointment as a child care officer. Training is provided in two stages: (1) a basic course in social science, followed by (2) separate professional training. Such training is given in 14 centers, 12 of which are in universities; the courses vary in organization and approach. Graduates in subjects other than social science and non-university students who are at least 25 years of age may take the approved courses in London or Manchester. These courses are planned in co-operation with the Central Council of Child Care, and grants are available to students from the Home Office Children's Department in London. The training of child care officers includes much that is common to the training of all social workers (303).

About a quarter of the 1,300 child care officers employed by local authorities are fully trained and qualified. The remaining three-quarters are divided evenly between those who are partially qualified

and those who have no formal qualifications. About 220 additional qualified child care officers are needed each year by local authorities; this does not include the staffing of voluntary societies. Only 55 child care officers qualified in 1960, but this number was increased to about 160 in 1963.

Child care officers decide on the kind of care most suitable, and arrange for children's placement. They need a thorough knowledge of adoption procedures, pertinent social legislation, and the purpose and organization of various schools (303). The problems they face are described by Braithwaite in his account, *Paid Servant*.

The officer's work is often more complicated when the family has a handicapped child. The parents need emotional support when they feel guilty about this child. In the case of young wage earners, the child care officer must strike the right balance between supportive friendship and too close a personal relationship. Handicapped youngsters in many cases are especially eager to form a close affectionate tie with the officer (65). A handicapped youth needs special help when as an adolescent he leaves school and returns to a home where the standards of behavior he learned in the special school or institution may not be reconcilable with the standards he finds in his home, even though he has kept in close touch with his family and has spent short vacations with them. Such a youngster needs hostel accommodation to substitute for a home situation to which he cannot or should not be required to adjust (14).

The child care officer helps to plan training or finds employment for boys and girls leaving foster homes or institutions at or after school-leaving age, or when they "come into care" after the age of 14 (65). Handicapped youth may need special help in choosing a feasible kind of occupation or training, and then in adjusting to the job situation. This frequently requires the best efforts of both the youth employment officer and the child care officer.

In March 1960 there were over 80,000 children in care, of whom 61,729 were in the custody of local health authorities, working through their Children's Departments (65). By 1966 local authorities were providing care for a total of about 65,000 (314). The total number of children in the care of both local authorities and voluntary organizations was 79,221 in 1965, or 6.05 per 1,000 of the estimated population under the age of 18. (107).

Some welfare officials feel that the Children and Young Persons Act may actually be responsible for the large number in care because relatives and neighbors make less effort to look after the children of a sick mother now that it is generally regarded as the duty of the child care officer to do so. About two-thirds of the children who "come into care" in the course of a year will leave care again by the end of the year (65).

When an adequate foster home is not available for a child, a small

residential "home" is now generally preferred to the larger institutions more frequently established in the past (108). However, some experts question whether the disapproval expressed in the Curtis Committee report concerning large Homes or institutions for children is necessarily applicable to those that exist today. A recent investigation of two large cottage-plan establishments which together provide for between 300 and 400 boys and girls aged 5 to 15 indicates the many ways in which the individuality of the child is preserved. One possible advantage of such a placement over a foster home is that if a child's placement for some reason is unsatisfactory in one cottage, either the houseparent or the child himself is free to notify the superintendent and the child moves to another cottage. Such a change is undoubtedly easier to effect and produces less traumatic results than a change from one foster home to another. One disadvantage that the secondary pupils do face is that few of them have friends from outside the Home to visit them, and few participate in outside clubs and activities apart from Sunday School and church membership (314).

Voluntary societies now provide an alternative to placement outside the home by means of grant programs under the child care officer which enable relatives to keep the children at home through financial and other practical assistance. One of the first of these arrangements was the Auxiliary Boarding-Out started by Dr. Barnardo's Homes, which also have a plan in which some of their cottages are set aside for whole families threatened with disintegration if help is not given. Grant programs for care in the child's own home are also provided by the Church of England Childrens Society and the National Children's Home (65). The White family is an example of those receiving this kind of aid:

Mr. White died when the oldest of the four children was ten years old. Joan was especially distressed by her father's death; Mary was very delicate, tiny for her age, and not very bright; George and Fred had a tendency to asthma, and Fred was accident prone. A grant from the Family Assistance Scheme and emotional support from the Child Care Officer made possible an eventual successful adjustment for all four youngsters (65).

Though no child can be received into care after the age of 17, children already in care remain in that status until their eighteenth birthday, and boys and girls whose education is continued after that age may receive financial support until it is complete (93). It seems to be difficult for children to adjust satisfactorily to placement in an institution or foster home if they are adolescent or nearly so when they come into care. The new situation is more acceptable if siblings are included, and efforts are usually made to keep brothers and sisters together (65).

Only 15 to 20 years ago the child care officer in many instances had to refuse to allow the placing of a child in a particular home because it lacked the minimum amenities, though few such cases occur today. Another basis for refusal is that of would-be foster parents who wish to take a foster child as a means of helping their own physically or mentally handicapped child, which may or may not be in the best interests of the child to be placed.

Some placements of handicapped children work out very well indeed, as in the case of Johnny:

He was so severely physically handicapped that he could not walk or even stand alone, and he was so handicapped mentally that he could never learn to read. He had no skill with his hands and any sort of handwork was impossible for him. He was completely one of the family, and for this reason he certainly had a happier childhood than he could have had in a Home, and when at seventeen he went to an institution the family visited him as if they really were his own (65).

An increasingly common practice is for boys or girls who are living in Homes (institutions) when they reach school-leaving age to go out to work while continuing to live at the Home, though for various reasons many still must leave the Home when they get a job. Growing up in a Home, they find it more difficult to learn to become independent than if they had grown up in a foster home, but it is impractical to permit many of them to remain in the Home while working. Therefore most of them must leave soon after they finish school, and if they cannot return to their own relatives they usually go to foster homes.

One of the great problems of these young people as they enter the world of work is therefore to find suitable accommodations within easy reach of their job (93). Although the Children Act empowers local health authorities to provide hostels for young people from 15 to 21 years of age, not every local authority has such hostels, and on receiving a boy or girl who is difficult to place in lodgings or in a foster home they may turn to a voluntary group for help, the local authority paying for their care and remaining responsible for them. Hostels may be for boys, for girls, or occasionally for boys and girls together, who are going out to work. It is, however, very difficult to find suitable staff for such hostels, partly because those who are suitable for residential work prefer to work with younger children, and partly because it is very difficult, anxious work since it is usually the most difficult boys and girls who are in the hostels. Hostels cannot accept girls who will not accept reasonable advice and rules. Those who need protected conditions and stricter discipline than is possible at a hostel may be received in training Homes (usually run by religious orders) where they can work for a time and then go

out from the Home to work locally. Though girls cannot be forced to go to such Homes, they often agree reluctantly because they know no other plan is open to them.

Child care workers are divided in their views about the value of hostels. Some think they represent an excellent stepping-stone from the protection of a Home to the independence of life in lodgings, and provide well for youth who are mentally backward or emotionally immature; the difficult benefit from the skill and understanding of the trained staff. But others feel that difficult youngsters who live together lead each other into trouble; one who is just becoming more stable might be upset by a newcomer or one who is disturbed. The boys and girls themselves are equally divided in their views about hostels.

Successful hostels must be small, which means that they are very expensive to operate, and the payments made by the youthful residents meet only a fraction of such expenses. Larger hostels are more practicable economically but they are less homelike and make it more possible for one resident to have an undesirable effect on another. Girls who have grown up in the Homes may have a special problem if they have not formed a very strong tie of affection with some one member of the staff or with some outside friend (65).

A Central Training Council has been established, and in addition to "child care" courses provided in the social science departments of some universities for officers and administrative staff there are now courses for housemothers, and persons in similar positions, which have been organized by local authorities and voluntary organizations (93).

MENTAL HEALTH SERVICES

After the handicapped youth leaves school, his emotional problems are dealt with through the mental-health facilities for the adult population as a whole. There may be a persisting association between emotional and mental (intellectual) or physical handicaps. Emotional disturbance may affect the capacity of the handicapped school leaver to profit from technical or industrial training, and it may also seriously affect his job performance. The methods of preventing and treating emotional maladjustment on the school leaver and adult level are therefore a matter of great concern.

The English term "mental disorder" includes mental subnormality as well as mental illness. Thus psychiatric beds by definition can be occupied by the severely mentally retarded as well as by the mentally ill.

The mental health problem, as stated in 1965 by the National Association for Mental Health, is as follows:

One woman in 9 and one man in 14 will spend some time in a mental hospital during their lives.

One woman in 20 and one man in 28 will be admitted for a second time.

One person in 100 will be admitted at least 4 times.

In England and Wales, for every person in a hospital there are two seriously disturbed people receiving treatment in the community.

At the end of 1964, 351,960 mentally disordered people were receiving either in-patient hospital care or local authority services.

About one in four adults suffers from psychiatric symptoms, mainly those of neurosis.

Nearly half the hospital beds in the country (47%) are occupied by mental patients, or a total of 189,449. Of these the mentally ill account for 130,527 (or 69%).

The average stay for a patient is now six weeks, whereas a generation ago it was 10 years.

One-third of the patients seen by family doctors suffer from illness of mental or emotional origin (233).

The history of the development of mental services shows that in the 18th century madmen were locked up in madhouses; in the 19th century lunatics were sent to asylums; in the 20th century the mentally ill receive treatment in hospitals. The Lunatics Act, 1845, established a permanent Board of Commissioners in Lunacy, with powers including the investigation of asylums. The Lunacy Act, 1890, made provision for certification, care, and control of persons of unsound mind, and the establishment and inspection of licensed houses for them. The regulations governing certification and compulsory detention remained in force till the Mental Health Act, 1959 (93).

The Mental Deficiency Act, 1913, classified mental deficiency into four categories: idiots, imbeciles, feeble-minded, and moral defectives, classifications that were only slightly modified by a similar Act in 1927. Both Acts defined mental deficiency as "a condition of arrested or incomplete development of mind, existing before the age of 18 years, whether arising from inherent causes or induced by disease or injury" (93). In the Mental Treatment Act, 1930, a distinction was made between the lunatic who might have intervals of lucidity, and the idiot, who was incurable. It was stressed in this Act that mental disorder should be treated as much as possible like physical ailments.

Widespread dissatisfaction with the terminology, treatment methods, and general attitudes concerning the mentally disordered led to

the appointment of a Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, whose report appeared in May 1957. The implications of this report were widely discussed in the press and in conferences such as those sponsored by the National Association for Mental Health in Manchester that year, and in London the following year. Finally in 1959 the Mental Health Act, based largely on the recommendations of the Royal Commission, was passed (242). This Act adopted a classification of mental disorder which included the categories of "mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind" (164). Under "arrested or incomplete development of mind" were listed mental subnormality and severe mental subnormality. It was stressed that mental disorder is an illness and should be treated as such, and that as far as possible long hospitalization should be avoided, with community care taking its place.

The Mental Health Act, 1959, also abolished the system of certification, and the Board of Control. Certification had been thought of generally as meaning permanent or dangerous mental derangement, life-long or hereditary mental instability. Those certified as mentally defective were thought of as severely defective and usually abnormal in appearance as well. In contrast, the report of the investigatory Commission which preceded the enactment of the Mental Health Act of 1959, stressed the wide range of cases included under those terms, with milder cases outnumbering severe forms, and being capable of remaining in the community. The Commission was seeking to remove the stigma of certification and to encourage voluntary submission to treatment, with mentally disordered patients being admitted to psychiatric hospitals on the same informal basis as the admission to hospitals of patients with other medical needs (327).

The success of this new approach is indicated by the following data: At the end of 1959, 38.6% of all patients in designated mental hospitals were being detained under compulsory powers of some sort or other, but in April 1961 only 6.5% were so detained. Furthermore, the National Association for Mental Health stated in its annual report for 1961-62 that whereas in 1958 some 30% of the admissions for mentally ill patients were under short-term compulsory powers, and 8% under long-term compulsory powers, the comparable figures during the first six months of operation for the Mental Health Act were 18.5% and 2.5%. When comparing the actual numbers of compulsory admissions, the figures in 1958 were about 31,000 short-term cases and 8,000 long-term, compared with 12,800 and 1,750 for the first six months of the Act (63).

Grounds for compulsory detention are carefully stipulated in the 1959 Act. When a person is suffering from mental illness or severe subnormality such compulsion may be exercised whatever his age,

but it is limited in the case of psychopathic disorder and subnormality to persons under the age of 21 (93). Compulsion ceases at age 25 unless the patient is already in a hospital and releasing him is considered potentially dangerous to himself or to others, and unless he has been sent to a hospital or placed under guardianship by an order of the Court. However, many will continue to be treated in the community or in the hospital without invoking powers for compulsory treatment (218).

Some fears and misunderstandings related to the 1959 Act have needed to be explained away. Some people feared that a flood of violent, maniacal patients would suddenly be turned loose, that local authorities would be swamped with hundreds and thousands of freed patients demanding their services, and that the mental hospital would become a place to be avoided at all costs since it would be "a dump for incurables" (326). Of course none of these things occurred.

The total of the "mentally disordered" receiving treatment hovers around 200,000. The National Association of Mental Health states that in 1960 the number of beds allocated to the mentally disordered in the Hospital Service was 212,000, nearly half the number of beds allocated to all forms of illness (44%) (68). At the end of 1961 there were 136,346 mentally ill or psychopathic and 61,164 mentally subnormal (either subnormal or severely subnormal) in-patients under the care of a psychiatrist. The total of 197,510 patients represented a ratio of 4.3 per 1,000 population. This report also gave 5.0 per 1,000 population as the lowest estimate of the need for services at the end of ten years. Three of the 5 will be mentally subnormal. At present about half the mentally subnormal and nearly all the mentally ill or psychopathic are aged 16 or over (200).

Both the number of patients admitted to mental hospitals and the number discharged from them has been increasing for many years, while the average length of stay has been decreasing (200). It is estimated that in England and Wales there are between 70,000 and 80,000 new cases annually, of whom 80% may be discharged within a year (218). Since 1947 first admissions have increased by 66%, and readmissions by 400%, but in spite of these figures, the average hospital stay continues to shorten. Such trends reflect both earlier detection and treatment which now emphasize community care and the goal of helping the mentally disordered to live as normal lives as possible. The increase in first admissions is greater for depression and personality disorders than for schizophrenia. The four most common categories of patients in psychiatric hospitals are depression, schizophrenia, mental subnormality, and senility (63).

The increase in out-patient care may be reflected in the future in a decrease in the demands for in-patient care of the mentally ill. The number of beds allocated to the mentally ill in 1960 totaled 151,899, but the number projected for 1975 in England and Wales

is 92,047. There will be far fewer of the very large mental hospitals, and more in the middle range of size. Though the mental hospitals that remain are likely to continue to be administrative and clinical centers for the provision of psychiatric services, particularly for long-stay patients, some regions are already using a system of comprehensive units for day- and in-patients located in or associated with general hospitals, which represents a diffusion of psychiatric services (308). At present 131,000 of the 136,000 beds occupied by psychiatric patients are in mental hospitals and only 888 in teaching hospitals, but by 1975 it is predicted that psychiatric beds in general hospitals will have increased to 20,000 (159).

Psychiatric treatment in the context of a general medical hospital is increasing, partly because a psychiatric patient can more easily be persuaded to go to a general hospital than to one designated as a psychiatric hospital. In addition to the persistence of attitudes of suspicion and fear toward a label suggesting mental illness, there is the fact that general hospitals are usually more familiar, and are nearer the home of the patient. A distant psychiatric hospital can present transportation problems for visitors. At the same time, there is the disadvantage that since psychiatric treatment produces results more slowly than other forms of medical treatment, there is need for a longer period of time for treatment than the general hospital is geared to provide (63).

Changing methods of treatment within the hospital itself assure more rapid recovery of mental patients. In place of the traditional tasks involved in the maintenance and operation of the hospital itself, useful industrial operations in a sheltered workshop within the hospital provide a much greater variety of activities. As an example, at St. Wulstan's Hospital in Malvern, Worcestershire, to whose workshop patients are referred from 12 other hospitals, patients are classified into four groups on the basis of their work capacities, and may be moved from group to group as their abilities improve or deteriorate. The work includes assembling toys; packing needles in cartons; packing automobile parts; pinning, assembling, and packing carnival and fraternal-order supplies; cleaning and repairing sports equipment such as cricket pads, gloves, and hockey pads; dismantling and salvaging parts from telephones; and assembling electrical supplies. Most of the products are manufactured on contract, the hospital picking up materials and delivering products. Workers are paid a fair industrial rate (77).

Reinforcement of the social gains resulting from such vocational activity is the chief purpose of a newsletter that is posted for the patients, giving them information about the amount of production, types of products turned out, and location of customers, besides listing the names of those who were on time or tardy for work. Personal news and the progress of various sections of the workshop are also

included. Persons who have been able to leave the hospital and obtain outside employment are mentioned (77).

The responsibilities of local authorities for prevention of illness and for care and after-care now include both mental illness and mental defectiveness. Before the Mental Health Act, 1959, such provisions were *obligatory* for mental defectives but merely *permissive* for the mentally ill. There is a steadily growing realization that kindly care in a hospital that removes all responsibility from patients can be just as damaging as harshness. Local authorities, to make possible community rather than hospital care, provide such services as residential accommodations, facilities for occupation and training, and the aid of mental welfare offices (83, 218). When it is judged that in-patient treatment is unnecessary, there are over 400 adult out-patient clinics and 200 child-guidance clinics and centers to serve the mentally disordered (218).*

After-care is also provided by voluntary organizations such as the Mental After Care Association which was founded in 1879. During 1965 this group dealt with 1,300 cases referred by voluntary and statutory bodies, and provided over 400 holidays in its seaside homes for patients still hospitalized. The association has found that at times it can deal more flexibly with human problems than can local authorities hemmed in by laws and regulations (162).

Provisions for treating the psychopath during and after his hospital stay is the same as for other kinds of mental illness, except that more authorities may be involved—not only the hospital and local authority social workers but also the Ministry of Labour, the National Assistance Board, the Courts, and various voluntary agencies. Close cooperation of numerous agencies is usually necessitated by the difficulty of treating the psychopath successfully (218).

Rehabilitation procedures in the psychiatric hospital depend in part on whether the patient is likely to remain in an institutional setting, or is expected to return to or continue living in the community. Active treatment and a carefully organized program of convalescent activities precede his release from the hospital. The curative process is accelerated by increased freedom within the hospital and the development of occupational, recreational, and cultural interests (218). To smooth the transition from hospital to home, some hospitals organize relatives' groups in which doctors and social workers discuss the methods of treatment and give suggestions for living with the patient after discharge. It is interesting to note that a government report warns against the "single-patient" psychiatry more common in the U. S.

We must guard against the process which in North America is tending to eliminate the doctors' direct experience of

* A detailed description of the varying programs of mental health services provided by local authorities is given in the U. S. government publication on "Community Mental Health Services in Northern Europe" (77).

the family, so that already in the U.S.A. only eight per cent of medical consultations take place in the home (200).

Another warning voiced by Professor Timuss pointed out the fact that:

At present, we are drifting into a situation in which by shifting the emphasis from the institution to the community we are transferring the care of the mentally ill from trained staff to untrained, or ill-equipped staff or no staff at all (233).

Community care for the discharged patient begins with the out-patient clinic of the mental hospital, and the psychiatric social worker of that hospital. Also involved are the general practitioners and the mental welfare officers of the local authorities (63). Keeping the mentally disordered person at home depends in part on other services inside the home, such as the advice and support not only of the social worker but also of a health visitor; the services of a "home help"; access to training, occupation, and social facilities in centers and clubs; and the availability of short periods of residential care. Where it is inadvisable to keep the person at home, but where community care is still the goal, efforts are made to place the person in a foster home or suitable lodgings, with children separated from adults and the mentally ill separated from the mentally subnormal (200). It is recognized by mental-health authorities that the home may become a "one-person ward" for a mentally disordered patient.

New facilities like day hospitals, night hostels, sheltered workshops and training factories, give us the chance to offer help to patients and their families on a much wider plane than that of the conventional hospital (63).

The needs of a mentally disordered person can often be taken care of satisfactorily in the "extended family" unit as defined by sociologists. Though this unit is gradually disappearing, it still flourishes in a few well established and stable communities, especially in the industrial areas of northern England (200).

Concern about continuity of treatment between hospital and home is illustrated by a 1965 conference on that subject, sponsored by the National Association for Mental Health (238). The after-care of patients, now recognized as so important in their achieving successful social rehabilitation, is provided by the hospital or by the local authority according to the type of patient and the availability of services in the area concerned. The way in which the hospitals and the local health authorities cooperate in after-care varies widely throughout the country (218). In Plymouth the Nuffield Trust is shortly to open a comprehensive community mental welfare center, the first of its kind, integrating the hospital and local authority psychiatric

services, and where training groups of general practitioners and other workers interested in mental health may obtain experience. However, services are less well integrated in other areas, where there may be a lack of liaison with after-care services when the patient is discharged from the hospital, or where it is difficult to get appointments for psychiatric patients or beds in hospitals because of long waiting lists. It is recommended that the general practitioner in the patient's home area be contacted *before* the patient is discharged (63).

The general practitioner is in a key position to help the discharged patient, but unfortunately he usually has had very little psychiatric training. There is no final examination in psychiatry as in medicine and surgery. To serve his mentally disordered patients adequately, the general practitioner also needs ancillary services such as those of a psychiatric social worker. Both the family doctor and the relatives and friends of the patient feel the aggression, the guilt, and the burden involved in such a case; therefore the relatives and friends need help too (63).

The health visitor is also recognized as an important part of the after-care program provided by local authorities. In Surrey it has been arranged for all health visitors to attend regularly certain programs of instruction at the mental hospitals for the subnormal concerning the causes and prevention of mental ill health. It is expected that in their contacts with families they will be better able to identify and cope with the "prepathogenic conditions" which lead to mental illness.

In addition, it is apparent that highly trained psychiatric social workers have an extremely important role to play, particularly in providing the needed casework for individual ex-patients and their friends and families. They are often found in the mental hospitals, from which they follow up the patient and establish contact with the general practitioner, the Disablement Resettlement Officer, the local authority, and also the family (218).

The number of social workers employed by local authorities increased by 119 in 1962 to a total of 1,247 (200). It is anticipated that in the future more of them will be working directly with local authorities, in some cases acting as advisors to well trained mental welfare officers (218).

An interesting development in the field of community care and after-care is that of the Industrial Therapy Organisation which first started in Bristol in 1960, and expanded to four groups by 1963. The ITO is considered to be the second stage of a three-stage plan to rehabilitate long-stay and long-unemployed patients with residual disability (117), as described in the section on *Employment*. This plan gives the patients six months of training in the organization's own factory, supervision during work, and proper living accommodation. If the workers earn less than a living wage, the organization

will pay them at least the minimum rates, the Ministry of Labour providing 75% of the difference.

The Industrial Therapy Organisation emphasizes the place of work in the treatment of mental disorder. Not only the performance of meaningful work that leads to eventual outside employment is important, but also receiving in return society's symbolic reward for such activities in the form of wages. ITO also provides the progression from offering work in the "factory in a hospital" to building a bridge between the hospital and the community by providing work in a factory in the community itself. The psychiatrist in the mental hospital can help the patients adjust to the "factory in the hospital" but the local authority and community services must help provide the opportunities in factories outside the hospital as is done in Bristol (244). Recently the ITO has leased a factory where 100 patients from the city's mental hospitals will be employed (233).

In another experimental program, the sequence of opportunities offered to a group of long-stay deteriorated patients started with basic habit training and progressed to the performance of industrial operations such as packing parts for a large car firm, folding cardboard boxes, filling Christmas stockings for a large chain store, and putting nylon fishing lines on reels. When the experiment was publicized, some manufacturers approached them with the thought of obtaining cheap-rate work, but the hospital authorities insisted on normal pay rates plus a percentage in lieu of factory overhead. At that time 58 mental hospitals—more than half those in the United Kingdom—were providing work of this kind. During the first year of this work at Banstead Hospital in Sutton, more than 100 schizophrenics were discharged and had not been readmitted. However, in three years this number of discharges from the factory unit dropped to zero, because a new though satisfying form of institutionalization had been created. The next effort was to build up an attitude of expectation of recovery and discharge to offset prevalent attitudes that a mental hospital represents permanent accommodation (244).

Future needs in community after-care include a much larger number of hostels and social clubs for recently discharged patients (218). It has been estimated that by 1969 there will be over 500 hostels for patients discharged from mental hospitals (334). Mental-health workers emphasize that the hostel as a rehabilitation service should be a true joint enterprise between the local authority and the mental hospital (63). The hostel should be located not on the outskirts of the community but within the town itself so that it is in a very real sense a part of the community (239). In 1962 local health authorities opened a further 12 homes and hostels for the mentally subnormal and 9 for the mentally ill (200). The principal voluntary organizations helping in making such provisions are the National

Association of Mental Health and the Mental After Care Association (218).

A number of suggestions for the establishment of effective hostels of this kind are found in the 1961 publication of the National Association for Mental Health called "Hostels and the Mental Health Act" (240). The hostel needs a well trained staff; there is still no nationally recognized course of training or qualification for those persons hitherto called duly authorized officers and now having to take on part of the duties of mental welfare workers, but at the same time there is a shortage of specially trained persons such as psychiatric social workers who are needed for staffing purposes. Health visitors "seconded" on full pay to mental hospitals for six months, as well as nurses trained in the field of mental health, are proving adequate.

Also the age, capacities, and special needs of the persons to be placed in hostels must provide the basis for referral. For example, Surrey has as its target the provision (for a total population of nearly 1,450,000) of 8 to 10 hostels for 200 wage-earning adults, 4 to 6 hostels for 125 dependent adults, 4 hostels for 100 long-stay children, and 2 hostels for 50 short-stay children. The optimum size is between 20 to 25 beds, as a compromise between the need for a homelike and friendly atmosphere (met by a small unit) and the need for economy of staff and administration (met by a large unit). At about the age of 16 transfer to the adult hostel takes place when training of a workshop character is needed. This transfer can be made easier by having a hostel with attached workshop near the children's hostel and workshop, as a separate section of the training center. The publication concludes with a list of do's and don't's concerning the establishment and operation of hostels (240).

Another future need is for a much larger number of psychiatric social workers, since many mental-health workers insist that the functions of these social workers should be expanded even further. It is believed that psychiatric social workers should become the regular caseworkers throughout the mental-health field because of the degree of disturbance in family relationships which may be involved, and which less well trained workers would not be able to deal with. The child guidance clinic should be brought into a closer relationship with the mental-health field as a whole, without severing its valuable administrative connections with the educational services, by means of joint staffing arrangements; for instance, the psychiatric social worker and the child guidance psychiatrist could have dual responsibilities of a similar nature. Family casework is found to be especially important for the family with a mentally handicapped child (63).

With the elimination of large isolated psychiatric hospitals and the increase of facilities for treatment nearer to patients' homes the

use of social workers jointly by hospital and local authorities is likely to spread (200). Since psychiatric social workers are increasingly in demand in a variety of settings, there is widespread concern as to whether this burgeoning need can be met by existing training programs (206). As a conference speaker dramatized this situation, there were only 8 psychiatric social workers employed full-time by local health authorities in 1951, and by 1959 there were still only 26. At this rate of increase, it would take another 53 years (AD 2014) before someone could say that there was an average of one psychiatric social worker for each authority! (239)

Another recognized need is for more and better hospitals to provide services for the mentally ill. The National Health Service published in 1962 "A Hospital Plan for England and Wales" which assessed present buildings, programs, and staff personnel, and estimated the nature and extent of changes needed over the next ten-year period (262). A ratio of 1.8 hospital beds per 1,000 population for mental illness is projected for 1975, though this estimated limit of requirements does not take into account any contribution from expanded community mental-health services, which are still very much in their infancy. Many more residential hostels are planned; although only four of such hostels specially designed for the mentally ill have been provided by local authorities so far, 150 are included in their programs for the next few years. Home care will also increase markedly as more trained social workers are recruited for work with the mentally ill. All such provisions will affect the nature and extent of hospital services needed for the mentally ill in the future. With increasing emphasis on small care units, some of the larger obsolete buildings may be abandoned. More extensive arrangements will be made for short-stay patients in small units as near their homes as possible, with the number of beds ranging from 30 to 60 or more depending on the population to be served. To facilitate the daily coming and going between these units and the community, accommodation will preferably be on the ground floors of the general hospital or in a separate building on the grounds of the hospital.

In addition to the ten-year plan to meet the need for additional buildings, there is need for a ten-year plan for the education of doctors, particularly psychiatrists, or ordinary undergraduate training in psychiatry for doctors and nurses, with a final examination in psychiatry for all doctors (that does not now exist). Every doctor should have a refresher course every five years and should have some financial incentive for taking one. Other personnel needs can be met in part through more adequate use of voluntary services; for example, hospital staff services can be supplemented by using voluntary workers in the "friendship" role, such as through the Association of Friends of the Hospital, or branches of the National Association for Mental Health. In addition, many more mental

welfare officers are needed, with better pay provided for them, as well as better training (63).

A pilot course was held in Portsmouth in January 1965, by the National Association for Mental Health, in conjunction with the Society of Medical Officers of Health, to increase medical officers' understanding of mental health and to interest them in the developmental difficulties of the school child, thus enabling them to make an earlier diagnosis of maladjustment. Other special courses have been established by the National Association for Mental Health for personnel working with the emotionally disturbed, such as for matrons of convalescent homes, chaplains in psychiatric hospitals, child psychiatrists, and the staff of residential special schools (233).

More intimate cooperation and understanding between lay and professional groups is needed. Trained nurses and psychiatric social workers can help to bridge the gap between the psychiatrist and the general public, too often separated by barriers such as vocabulary. Public interest and support might increase if most laymen had a better understanding of the vocabulary, the concepts, and the policies of those working in the field of mental health. Public education in mental-health matters goes beyond creating a warm acceptance of the humanitarian open-door principle, with maximum liberty for patients, to an awareness of the accompanying concept of calculated risk and of the fallibility at times even of psychiatrists in judging when a patient is not potentially dangerous to the community. The need for further cooperation and understanding is also illustrated by the fact that at present the community and local authorities are at the mercy of the psychiatric hospital as to who is admitted and who is to be left as a problem for the community services, as well as to when the patient admitted is to be discharged (63).

Such cooperation must be secured against a background of increased public understanding of the nature of mental handicaps and mental health. One effort to educate the public along these lines was that of the National Society for Mentally Handicapped Children when, in conjunction with the National Association for Mental Health and other societies, it organized a Mental Health Week for June 5 to 11, 1966. This was the first of three annual Mental Health Weeks to culminate in the International Congress of the World Federation for Mental Health in 1968.

English authorities recognize that the cost of an adequate program of mental health services is obviously high. But as pointed out in a 1965 conference on the subject of the price of mental health, the price of disregarding research findings and failing to provide the services needed would in the long run be far greater for society (245).

SERVICES FOR THE MENTALLY SUBNORMAL

It is estimated that there are over 100,000 mentally subnormal persons receiving some kind of care in hospitals, homes, or under private guardianship (218), and that there are about 27,000 mentally subnormal children on the registers of local health authorities in England and Wales, including 18,700 children at home and 8,300 in hospitals (202). In England as in other countries there are no up-to-date registers of all mentally handicapped persons, and so the actual size of the group for whom services are provided is still not accurately determined (372).

From the group of mentally subnormal children has been differentiated the autistic child whose behavior often leads to an inaccurate classification as mentally subnormal. It was estimated in April, 1963, that there were between 3,000 and 4,000 autistic children who were no longer listed as mentally subnormal (40).

The mentally subnormal (trainable mentally retarded) are provided for at present in training centers for the less severely handicapped: junior training centers for children 5 to 16 years of age, and senior or adult training centers for those over 16. The more severely subnormal (custodial mentally retarded) are committed to psychiatric hospitals, although progress is being made in enabling these persons to remain in the community, either at home or in another form of residential accommodation. The actual range of IQ's included in the mentally subnormal and severely subnormal categories varies considerably from one center or hospital to another; this depends in part on the nature and variety of the facilities available in a particular area.

The development of special training programs and facilities for the mentally subnormal is essentially a twentieth-century phenomenon. The first specific provision for mentally handicapped children came in 1848, but the first day school did not come until 1892 (39). In 1904 a Royal Commission on the Care and Control of the Feeble-minded was appointed to investigate the needs of the feeble-minded and other mentally disordered persons who were not considered certifiable under the Lunacy Acts, and the need for special forms of treatment for them and for idiots. The Commission's report in 1908 was followed in 1913 by enactment of the first Mental Deficiency law which obligated local authorities to make suitable provisions for defectives. The first occupation center outside a hospital was founded in London in 1909 (202).

The Central Association for the Care of the Mentally Defective stimulated interest which resulted in limited numbers of new centers with a 50% government subsidy given to local authorities for this purpose. The Mental Deficiency Act of 1927 required local authorities to provide suitable *training or occupation* for defectives who were under supervision or guardianship or had been sent to certified

institutions. This led to an increase in the number of new centers provided by local authorities and a decrease in the number provided by voluntary societies. By 1938, 60 local authority centers and 95 voluntary ones provided a total of about 4,000 places (202).

World War II and financial difficulties in the early years of the National Health Service resulted in a decrease in these places. Gradually local authorities have built new centers and taken over voluntary centers until by 1959 there were 435 local authority centers and 20 voluntary ones providing for 17,500 persons. The 1957 report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency had stated that a principle for future development should be a movement away from institutional care toward care in the community. The National Health Service Act, 1946, had required that local health authorities establish training centers for the mentally subnormal, and the Mental Health Act, 1959, empowered local health authorities to require parents to send their mentally subnormal children to such centers.

The change in name from "colonies" to hospitals in 1946 was a recognition of the change from custody to care and the possibility of return to the community. Also the change in title from "Occupation Center for Adults" to "Adult Training Center" reflected a change of purpose. Instead of mere occupation and day relief for parents, the aim now is to bring as many subnormals as possible to a level where they can be employed in the open labor market even though these are persons in general with IQ's below 50 (282).

Even more important than the change in terminology was the change in attitude and purpose which underlay the Mental Health Act. The Mental Deficiency Act of 1913 was based largely on erroneous eugenic arguments concerning the possibility of contamination of the race if the subnormal were allowed to reproduce, and it also was excessively concerned with compulsory detention. The Mental Health Act of 1959 was based on the premise of making medical and social care as fully and as easily available to a patient with a mental disorder as to one with a physical disorder. Thus the Act reflected a trend away from institutional care and the substitution of medical for judicial decisions in the case of mental hospital admissions and discharges. In this way mental retardation became a medical problem instead of a legal one.

Programs of training for those working with the mentally subnormal gradually developed. Certificates of Proficiency in the Nursing of Mental Defectives were first awarded in the 1890's. In 1919 the Board of Control approved the six-week courses for Supervisors and Visitors of defectives, employed by local authorities. The Board paid half the expenses of sending one or two supervisors to take the course in a given year. Training courses for both hospital and local authority staff were begun in 1936. By 1959, there were 2,149 per-

sons employed in training centers, aside from domestic staff and escorts. Of these, 363 held the diploma of the National Association for Mental Health, 171 had a nursing qualification, 64 were qualified infant nurses, 42 were qualified teachers, 14 occupational therapists, 12 social workers, and 17 had a trade qualification. Thus a total of 683 persons had special qualifications, or 32% of the employees (202).

The National Association for Mental Health is now the recognized national training body for staff of the training centers. Holders of the Association's diploma qualify for a nationally negotiated salary scale; these diplomas represent the completion of a full-time year course and demonstration of practical and theoretical knowledge as well as teaching ability. The Association also runs two-year diploma in-service courses, as well as one-week refresher courses when requested by local authorities. Two-year courses of training are now emphasized in contrast to the earlier one-year courses (233).

The diploma course for the staff of junior training centers is open to persons between 20 and 40 years of age who are generally acceptable and have worked with children. The one-year course for the staff of adult training centers was organized in 1960.

The Minister of Health established in 1963 a training council, with Lady Adrian as chairman, for the staff of training centers for the mentally subnormal, to approve and promote courses for teachers of the mentally handicapped. The council brings together the Ministries of Health, Education, and Labour, and represents implementation of the 1962 recommendations of the Scott Committee (163). This Central Training Council for the Teachers of the Mentally Subnormal is encouraging the establishment of two-year training courses attached to institutes of further education in various parts of England, but the National Society for Mentally Handicapped Children maintains that the need is so urgent that a special Training College is essential for this purpose. In 1965 the Lord Mayor of the city of Birmingham pledged himself to support the society's venture by committing himself to raise the sum of £250,000 for the proposed Training College, to be situated in the West Midlands (267).

In 1965, during the second year of the Training Council's functioning, four new courses were approved for teachers of mentally retarded children and one for instructors of adults, thus bringing the total number of approved training courses to 13, with a total of 250 places. At the end of 1965 three more courses for instructors of adults were being considered. The Ministry of Health also sent a letter to local health authorities calling attention to the work of the Training Council and asking them to release staff for training and to provide opportunities for practice teaching in their centers. The Training Council issued a pamphlet describing the organization and content of the courses for teachers of mentally retarded adults, and

began to prepare a similar publication concerning courses for teachers of children. Plans were made for initiating the Department of Child Development at the University of London Institute of Education (195).

Recently the word "staff" has given way to the word "teachers" and indicates a shift away from the dichotomy of education and training which has separated provisions for the educationally subnormal from those for the mentally subnormal (146). The reluctance to think in terms of teachers as necessary for mentally subnormal children may have been due to two main reasons: (1) lack of understanding of the true function of a teacher, along with a tendency to think in terms of a curriculum beyond the capacities of mentally subnormal children; and (2) a utilitarian concept of education that considers the expense of providing teachers for mentally subnormal children would be unjustified because they will make little if any economic contribution to society in later years.

The Guild of Teachers of Backward Children and the National Association for Mentally Handicapped Children regard training programs of the National Association of Mental Health as still inadequate. They believe that both the length of training and the salary of teachers in training centers should correspond to that of teachers in regular or special schools. At present the pay is usually only half even if the qualifications are identical. Both the Guild and the Association want the training centers placed under the Department of Education and Science in order to correct this situation. At present most persons teaching in training centers are untrained; one in six has had a year's training, and only occasionally a teacher has had two years of training (297, 343).

Training Centers

In 1960 buildings and staff were greatly needed for both junior and senior training centers. There were 293 full-time and 59 part-time junior centers providing for 10,500 children or about 80% of the cases, leaving 2,600 children without such training. There were at least as many more awaiting places (41). A year later, about 400 local health authority occupation and training centers and 20 voluntary centers provided a total of 24,000 places, 57% of which were for children, but there were still 5,924 on waiting lists (40). By the end of 1962 local health authorities were providing training for 13,833 mentally subnormal children and 12,159 adults, including some being trained in their own homes (200).

As a testimonial to President Kennedy's interest in the mentally handicapped, his name was given to a new junior training center for 130 severely retarded children, which was opened by the West Ham Council in 1964. Children can enter the John F. Kennedy Centre as

early as doctors permit them to. It is a one-floor center costing £120,000, with an indoor sandpit, a wading pool, and a heated swimming pool for beginners. The teacher-pupil ratio is one to ten (348).

It is estimated that twice as many workshop places are needed for the adult mentally retarded over 16 as for those under 16, and that eventually about 30,000 places, or 0.65 per thousand, will be needed (200). Local authorities plan to provide 28,000 places by 1972, representing 0.55 per 1,000 population. One staff member for each ten children is recommended. The staff need in junior and senior training centers is estimated at 5,133 by 1972; of these, 1,900 are teachers — 1,500 needed by local authorities and 400 by hospitals. Training programs expect to enroll 150 to 200 new recruits and provide training for 50 of the existing staff each year (202).

Attendance at junior centers can now be enforced, and local authorities can provide boarding accommodations when appropriate. The junior centers are supposed to provide only for children up to age 16, but "one finds men and women who have stayed on in the top class until they are twice or three times 16 years old" (327). This happens when the adult is quite tractable, when there is no adult training center, and when the junior center is not overcrowded. It is hard for a 16-year-old just to go home to sit and twiddle his thumbs; he gets bored and depressed, loses his habits of self-discipline, becomes less self-reliant, and perhaps even speaks less clearly.

The purposes of the senior training center are (1) to train and fit the mentally handicapped to secure and hold remunerative employment in the community; (2) to train those who cannot reach this standard to undertake some remunerative employment in the center; and (3) to train the more severely handicapped to undertake simple but yet useful and necessary tasks in the center (137). In the Middlesex center for senior girls, for example, the oldest of the "girls" is over 50. For some the center has provided the first chance to "grow up," as shown by the fact that their mothers always dressed them in schoolgirl cottons and short white socks. They learn simple housework and cooking, set the tables and take turns waiting on them, do flower arrangements, and have a choice of many kinds of handwork.

Many of them reveal that they already know the elements of household jobs, and, rather pathetically, will say: "I've watched Mother doing it at home, but she would never let me try myself" (327).

The well equipped and attractively decorated "powder room" at the center has done more than any amount of admonition to develop in the girls concern about personal appearance and the self-respect that results from such personal care. A center for older boys and men in Leeds provides work in assembling metal machine parts, making concrete blocks, and making and repairing toys. One group of young

men there made Christmas cards from a linoleum block designed and cut by a member of the group (327).

Birmingham in 1960 maintained a total of 7 junior training centers with 250 places for boys and girls aged 5 to 16. There were 67 names on the waiting list. The city also had two senior centers for boys and men and one for girls and women attended by a total of 200 persons, most of them part-time only. Here there was a waiting list of 125. This included 50 children at junior centers who were due for promotion to the senior centers (34).

The Bush Training Center in Bristol, which includes both a junior and a senior center, is the largest in the country. It provides day training for 390 mentally subnormal and severely subnormal children and adults of all ages. There is also a small residential unit for 20 children. Transportation is provided for some children. The Special Care Unit provides for 40 children who are very young, severely physically handicapped, or maladjusted, and who cannot participate in the activities of the Junior Training Centre. The staff of 47 full-time and 29 part-time persons includes a remedial gymnast, speech therapist, educational psychologist, music and movement teacher, physiotherapist, and teacher of the deaf (34). Primary emphasis is given to social development, good personal habits, story-telling, music and rhythm activities, singing and drama, handwork, and painting. Older youngsters have specialized practical training like housecraft for girls and carpentry and metalwork for boys.

The success of the Slough Hostel and Training Center established in 1962 by the National Society for Mentally Handicapped Children to enable mentally handicapped young people to take their place in the industrial community has encouraged the organization to make plans for a Rural Training Center in southwest England. The National Farmers' Union and the National Union of Agricultural Workers have supported this idea enthusiastically (267).

The chief factors which might affect the future need for places in junior training centers are (1) any development in educational methods which would alter the assessment of the suitability of children for education at school; (2) any development in methods of training which would bring more mentally subnormal children within its scope; (3) increased willingness of parents to send their children to training centers as facilities improve; and (4) continued improvement in life expectancy. The need for senior training centers is affected by (1) the availability of suitable open or sheltered employment; (2) the success of training, whether junior or adult, in enabling trainees to take open or sheltered employment; and (3) the need for those taking open or sheltered work to return temporarily to a training center (200).

Both types of expansion depend also on the availability of suitable staff and the extent to which residential accommodations are pro-

vided, the latter being particularly important for the senior group. Future plans envisage the provision of about 10,000 places in hostels by 1972 (40). As more specially trained teachers are given positions in regular schools, some of the more able youngsters from the training centers will be able to transfer to them. It is still extremely difficult for a mentally subnormal child to be transferred from a training center to either a special or ordinary school. However, a child ascertained as ESN and sent to a special ESN school may be easily changed to an ordinary school (345).

Mental Hospitals

About 8,000 children are hospitalized because of mental subnormality in England and Wales (67). Mentally subnormal adults 16 to 25 years of age in hospitals number 44,000, or about four-fifths of the total resident hospital population (202).

In general the institution or hospital for the mentally subnormal is undergoing many changes. Not only the size but also the location are being altered, particularly in view of the need to integrate them with the more central preventive and curative health services.

Possibly time may allow a diminishing need for most, if not all, of the persisting undesirable uneconomic prison-like buildings in which the medical and nursing staff still struggle to give their very best service for health and happiness to the many. A dull, dismal and dreary environment is no help at all. Happily, already the hard-working staffs have pressed on with improvements worthily aided by alert and enterprising administrative officers (239).

Methods of both medical and psychological care have also changed. The psychiatric hospital is less frequently regarded now as a "dump for incurables" even though some patients will continue to need the protection and long-term care of the institution. Integration of the historically separate hospital provisions for the mentally deficient and mentally ill will be accelerated by the broader training planned for hospital personnel.

Progress in securing improved facilities for the mentally subnormal is being made through a ten-year hospital-building program of the National Health Service. It has been found difficult to estimate how far beyond the present inadequate provision of 1.3 beds per 1,000 population it will be necessary to go. On the one hand are factors such as long waiting lists, the increased longevity of the subnormal and severely subnormal, and the greater willingness of parents to seek hospital admission for their children, at least on an informal basis. But on the other hand the expansion of community services will remove or postpone the need for hospital admission in

many cases, and will enable patients to be discharged. Further research on mental subnormality may make it possible to prevent the occurrence of certain forms of subnormality. These many unknowns suggest that any current plans may need radical revision later on. There is agreement, however, on the need for a changing type of treatment. Beds for these patients do not need to be in a general hospital. The subnormal are to be cared for separately from the severely subnormal and in comparatively small units, preferably with no more than 200 beds, and located if possible in areas where after training the patients may obtain employment and return to the community. Though severely subnormal patients will still be cared for in separate hospitals, severely subnormal children with additional physical handicaps will be placed where possible in a separate ward of the pediatric unit of a district general hospital (262, 263).

The advantages of smaller residential units for the care and training of severely subnormal youngsters has been demonstrated by the results of experimental programs. A national hostel and sheltered workshop unit—a residential adult training center—is maintained by the National Society for Mentally Handicapped Children (formerly the National Association of Parents of Backward Children) at Slough, Buckinghamshire (265). Each of two “villas” accommodates a “family” of 15 severely subnormal young people aged 16 to 25, of both sexes, each villa having its own set of houseparents. Work and social training are integrated for the trainees, who are sponsored by local authorities to whom their progress is regularly reported. This experiment in workshop training is one of the first attempts to combine social, educational, and industrial training in a community setting, and as such it serves as a pilot project for local authorities to be used as a basis for their own future planning. Another research project undertaken in conjunction with the Fountains Hospital at Broadlands, Reigate, revealed that the 16 severely subnormal children taught in a small experimental group progressed over twice as fast in verbal intelligence as a control group of the same number which remained in the institution (282, 374, 375).

Improved training of staff working with subnormal children has been reflected in their changed treatment of these children and resultant improvements in their development. In an experiment at the Brooklands Hospital, the staff were encouraged to talk to their young charges as their mothers would during the daily routines of dressing and going to bed, instead of grouping non-communicating youngsters together in the same ward and then seldom speaking to them, assuming they will never respond. The fact that in this experiment some mute children began to talk and the group as a whole showed great progress in speech demonstrated the fact that the mentally subnormal child is emotionally just as sensitive and responsive as normal children when given the same social stimulation (372).

The type of activity provided for patients in hospitals is also changing. Meaningful activity which helps to prepare the inmate for his return to life in the community is replacing mere busywork or labor used primarily to make the establishment more self-sufficient economically. Experimental school programs in the institution demonstrate capacities for appreciation and enjoyment which link youngsters more closely with the world outside the hospital and break down the rigid distinction between education and training. The possibilities of music, especially the playing of simple instrumental music, are increasingly being explored, as with severely subnormal adolescent boys from St. Lawrence's Hospital School in Caterham. In June 1965 the Society for Music Therapy and Remedial Music sponsored a day's program in London to demonstrate to 200 special teachers how music could be performed by severely subnormal physically handicapped children (230).

School programs in the hospital have also demonstrated that subnormal children have more learning capacity than generally recognized. Although their movements are slow when they face complex situations involving choice, improvement occurs when the learning situation is changed by subdividing tasks into a series of stages easily comprehended by the youngster and necessitating only simple choices (67). More emphasis is given to incentives such as social approval, which is found to influence the performance even of the severely subnormal. The retention and transfer of learned material is found to be good when sufficient time is allowed over a period of years for the acquisition of skills and information which normal children learn in a shorter period of time; this has led to more training for older adolescents (202). At Sotley's Park Hospital, in an experimental program with 147 severely handicapped children 96% of whom had IQ's below 50, those with IQ's of 40 and above were all being taught to read (67).

There is some concern expressed because of the limited extent to which children committed to hospitals for the subnormal are released. In a survey of 403 children under 16 years of age admitted to 17 hospitals during 1962, actually 24% of the children in this group had IQ's over 50, 14% had IQ's over 70, and 4% had IQ's over 100. Since additional physical handicaps and behavior disorders characterized only a few of these children, it had to be assumed that the children were committed for reasons other than their needing the special services of a mental hospital—either they had no home, or they needed residential care for a variety of social reasons that made it impossible for their families to care for them. Yet only nine children were discharged to local authority schools in 1962, four of them going to ESN schools. An additional 15 children attended local authority schools while still living in the hospital. These children all came from two hospitals which had a close relationship with the local

education authority. Of the 15, 11 attended secondary modern schools, one a junior school, and three an ESN school. It was believed that there should be more encouragement officially for this practice of sending to normal schools those children who are able to benefit educationally and socially from such an opportunity, at least for a trial period while still living in the hospital. The committee of the British Psychological Society which made this survey concluded with the following recommendation:

If social or medical needs prevent their living at home, mentally subnormal children should be educated in residential schools as far as possible and not sent to subnormality hospitals unless their educational and social requirements can also be satisfactorily met (16).

This committee also deplored the lack of educational emphasis in provisions for subnormal children either in the hospital or in the training center. They did not advocate more formal teaching methods directed toward reading and arithmetic skills specifically, but they did regret the isolation of hospital schools and training centers from "the main stream of education." They therefore urged the introduction of administrative measures to bring the educational work of junior training centers and hospital schools under the jurisdiction of the local education authority and the Department of Education and Science (16).

The concern of the committee is a reflection of the official policy of the Ministry of Health, as stated in a recent annual report:

Many of the considerations in the memorandum on hospitals for the mentally ill apply equally to hospitals for the mentally subnormal. It defines the aim of the subnormality hospital as the development in each patient of the maximum social dependence of which he is capable, not only to enable him to live as full a life within the hospital as he can, but to prepare him for return to the community wherever this is possible; and it points out that admission should be advised only if the special facilities the hospital offers are needed by the patient (195).

Changes in Provisions

Other changes and proposed improvements affect the mentally subnormal whether in training center or hospital. Broadening the concept of education to include other aspects of development rather than merely the intellectual is leading steadily toward a classification of provisions for all children as educational and on a longer continuum. There is increasing reluctance to give a rigid classification of "subnormal" to any person. The questioning of traditional concepts

concerning the nature and capacities of those labeled subnormal has led to intensified programs of research, such as those concerning remediable causes of mental retardation (306). Plans are under way to differentiate the training of 16- to 18-year-olds from that of adults as a whole by establishing special training programs for mentally subnormal school leavers, with a day-a-week release for further education (202).

An important emphasis is being given to the need of parents for aid in understanding and coping with mentally subnormal children in the home to forestall the development of the behavior problems that often complicate the later adjustments of the youngster and necessitate additional community attention. It was found in a Sheffield study that the very problems created by the mentally subnormal child in the home produced conditions preventing his optimal development; 29% of the families with mentally handicapped children had extra expenses on this account, 19% of the mothers suffered from nervous exhaustion, and in 15% of the families the siblings were adversely affected, usually as a result of the parent's emotional disturbance. Two-thirds of the subnormal children presented special management problems and lacked adequate guidance from their parents (67).

A domiciliary advisory service has been recommended, associated with special training centers, to help parents. More frequent home visits to give them the needed emotional support are being considered, particularly to encourage those parents with a child for whom medically speaking nothing more can be done, as they "need to know that they are not abandoned to meet all their problems alone" (96). Parents' groups for handicapped children, such as the National Society for Mentally Handicapped Children, are proving very helpful, but since parents often do not know about such organizations and therefore make little use of the published materials they distribute, more active membership drives and publicity for their efforts are needed. Another form of help to parents is the provision of temporary institutional care or an interlude in a short-stay center for the severely handicapped child for whom there is no institutional or training-center vacancy, or where there is no day center and the parents prefer to have the child at home (96). Earlier help for parents is expected to reduce the extent of problems with the adult subnormal, problems such as Bristol reports with an increasing number of marriages with a high risk of failure because of inadequate housing, finances and child care, and the increase in ill-advised installment buying (35).

Special kinds of help given the parents of children with severe mental handicaps, perhaps even combined with physical and emotional handicaps, make it possible for the children to remain at home instead of being sent to a mental hospital. Such help is given by a pioneering clinic at Queen Mary's Hospital for Children at Carshalton. Similar special clinics are being organized by local authorities

and by hospital pediatric units or in connection with the psychiatric departments of hospitals for the mentally retarded (140).

Help to parents may also include the alleviation of their worries about adequate provision for their subnormal children or youth after they themselves die. Some voluntary groups like the National Society for Mentally Handicapped Children make it possible for parents to contribute a reasonable insurance premium to a Trust Fund which ensures that the society will look after the youngster whatever happens in the future. Or such a provision may be financed by parents' leaving a suitable bequest in their will (267).

Help to parents is part of the program of after-care provided by some communities like Birmingham. The expansion of follow-up programs for the mentally subnormal after they leave school or institution is an important means for achieving the present goal of integration into the community. The after-care visitor is concerned with the development of character, judgment, and good social adjustment in mentally retarded youngsters, whether living at home and attending training centers or in open employment after leaving the special school or training center (34). Integration into community life is facilitated by the removal of the artificial barrier between the educationally subnormal and the mentally subnormal through inclusion of both groups in the same program of after-care. This was made possible by a provision of the Mental Health Act, 1959, which removed the distinction between the "statutory supervision" of children reported as incapable of education at school or requiring supervision after leaving school, and the "voluntary supervision" of subnormal special school pupils not so reported (164). Both groups are now visited and supervised on a voluntary basis. In Birmingham the after-care visitor also explains to parents in person the decision of the local authority to classify their child as mentally subnormal, and the services provided for him (34).

Another move in the direction of removing the sharp distinction between the educationally subnormal and mentally subnormal has been the formation of the group called the Guild of Teachers of Backward Children, which has sought to bring together all those professionally concerned with the backward or mentally handicapped child. This concern embraces all levels of mental retardation and educational backwardness (345). A similar emphasis is found increasingly in publications like Cleugh's "The Slow Learner," and the government publication "Slow Learners at School," which include all such groups and stress their common learning problems (39).

Changes in professional attitudes toward the finality of mental-test measurements in assessing mental subnormality are also leading to more flexible classifications. One expert has asserted that the English-speaking countries have been dominated by the influence of the intelligence test to a far greater extent than France, the country

of its origin. The assumptions of a rather rigidly determined level of intelligence delayed the appearance of research into the mental processes of the severely subnormal, like some pioneering Russian research into the capacities of the mentally subnormal for performing industrial tasks once considered to be beyond them (306).

Experiments with substituting boarding-out arrangements and after-care for institutional commitment have continued for at least thirty years. As early as 1936 six local authorities in northeastern England formed a North-Eastern Council for Mental Welfare to provide placement for defectives under guardianship, and to furnish social work in mental hospitals that included boarding-out and after-care. Places were soon found for girls to do domestic work in farm homes and for men and boys to do farm work. At about the same time, a boarding-out program was organized in Wales for mental defectives under the supervision of a trained social worker (99).

Most hopeful of all trends is the gradual shift away from former attitudes of fear, suspicion, and disgust once evoked by the mentally subnormal. After all, it was only a little over a half century ago that a bill was proposed in England (though later withdrawn) which would have forbidden the marriage of any mentally defective or mentally infirm person, on the grounds that procreation of their kind would cause the race to deteriorate. Deeply entrenched negative attitudes toward mental retardation do persist, as illustrated by the fact that although Meldreth Center is a place for mentally handicapped cerebral palsied children, the *Spastics News*, a magazine for parents of cerebral palsied children, makes no reference to the mentally handicapped factor. It appears to be relatively easy for parents to accept the fact that their child is cerebral palsied, and receives special treatment in that category, but it is much more difficult for them to accept any diagnosis of mental retardation in the same child. On the other hand, more and more people are coming to realize the basic human qualities shared with the youngster of low intelligence by asking themselves such questions as, "How would it be if I could not do what this person cannot do? What would make me behave in the way in which he behaves? What would make me react to this or that situation in a similar way?" (390). Such analysis leads to the realization that the mentally handicapped person cannot be understood as a "less" or "minus" quantity but as an exaggeration of one or another quality in one's own makeup. It means understanding the complex factors built into the totality of personality, so that in any single one a subnormal person could in individual instances be superior to another person with a higher IQ. This includes the multiple specific abilities of which "intelligence" is composed; in comparison with the so-called normal, differences found in the mentally retarded are greater in motor and sensory abilities than in their emotional life, in "the realm of 'moral values,' the realm of religion, of truth, of

fundamental knowing" (390). Such understanding leads to the recognition of the fact that the mentally retarded youngster, like others, has a basic need to realize that he is not completely dependent but has something to give, that he can extend help, love, and comfort to others. This need is being met best in community settings where he has learned to live with others and they have learned to live with him. Learning productive work is only a partial answer, for there must develop an awareness of the common moral and emotional experiences and values shared with others.

The situation regarding the mentally retarded in England is summed up by one writer as follows:

Whatever the intention of the Mental Health Act or of the Royal Commission which preceded it, it would be unrealistic to anticipate an immediate and profound transformation of mental deficiency practice. The problems which arise from the existence of overcrowded and unsuitable institutions, from inadequacies of staffing, from the administrative rigidities of the National Health Service and from popular fears and prejudices cannot be rapidly overcome. But new attitudes are abroad, and a legal foundation has been laid upon which major reforms can be built. Research has begun to throw new light on the potentialities of the mentally subnormal and to point out promising lines of advance. There can be little doubt that significant trends in the direction of community care and of more effective utilization of the capacities of the subnormal will gradually become more and more marked in our mental deficiency services (166).

Chapter 8.

Summation

THE IMPORTANCE OF RESEARCH

In the field of services for the handicapped, as in many other fields, there is increasing awareness of the importance of basic research — research that can give answers to many questions concerning the incidence of disability, the needs of the disabled, the adequacy of present provisions, and a thousand and one related questions. For example, the Working Party set up by the British Council of Rehabilitation of the Disabled to consider problems of handicapped school leavers pointed out that one of the main needs of future handicapped school leavers is for planned prospective research in all relevant fields, but particularly vocational research. More information is needed about the most appropriate employment for seriously handicapped persons, and the factors relevant to assumed “unemployability” (10).

The Working Party recommended:

. . . that every encouragement be given to the setting up of research projects designed to create a better understanding of the nature of all kinds of mental handicap and to assist in their more accurate diagnosis . . . and that within the wider scheme of training of teachers of handicapped children, adequate funds be placed at the disposal of appropriate University Departments of Education to enable them to undertake basic research in special education with adequate staff and equipment (10).

The recommendations made in this report were discussed at a conference organized in July 1965 by the Central Council for the Disabled in conjunction with the Standing Conference of Voluntary Organizations and the British Council for Rehabilitation of the Disabled; those attending were local education officers, youth employment officers, and representatives of voluntary societies (25).

Many publications have emphasized the importance of research in meeting the needs of the mentally subnormal. One of these many

publications is the PEP booklet on "Mental Subnormality and Community Care," which discusses in detail the contributions of research to this subject (166). The National Foundation of Educational Research publishes its findings in the journal, "Educational Research." The Polio Research Fund publishes a quarterly called "The Fund Reports." Some publications are devoted to a more limited area, such as the *Journal for Mental Deficiency Research*.

A particularly ambitious research project is the interdisciplinary National Child Development Study, now being administered by the National Bureau for Cooperation in Child Care. In this large-scale longitudinal study of normal and deviant children, a group of 16,000 children born in Great Britain in the same week in March 1958 are being followed up at three-year intervals. Not only will this investigation provide experimental evidence concerning suitable methods for conducting comprehensive studies of this kind, but it will provide information to form the basis for planning services for normal and handicapped children and to suggest preventive measures where adverse conditions are revealed. Of particular interest will be information on the long-term effects of various types of handicapping conditions (366).

Examples of special education research are those supported by the Ministry of Education in 1962. The Ministry, jointly with the Dulventon Trust, made a grant to Nottingham University to support an investigation of the problems of teaching deaf children, particularly to throw light on certain aspects of backwardness in the use of language by children with impaired hearing in relation to their linguistic, social, and ethical development. Another grant was made to University College, Swansea, for a three-year study by members of the Department of Education on attainment testing in special education in ESN schools (175).

There is close cooperation between statutory and voluntary agencies in planning and conducting programs of research. The Ministry of Education reported in 1963 that a grant had been offered to Moor House School for children with speech defects for a project to collect and publish a considerable amount of research data concerning aphasia and similar conditions which had been collected since that school opened in 1947. This work was to be carried out by the Medical Director of the school over a two-year period. Other examples of research programs are those supported by voluntary effort in the form of large trust funds. Research into the cause of blindness on a scale seldom undertaken before is being financed at London University by a £100,000 gift from the Sembal Trust.

A significant research project sponsored by voluntary sources is described in "Handicapped Children and their Families," a summary and evaluation of services provided for 600 handicapped children in three areas: Glasgow, the Sheffield Area, and Shropshire and other

West Midland counties. The basic technique consisted of interviews with parents and children, relatives, and various workers serving the children in some way. Most interviews took place within the home, though the child was also visited in school if he attended one. As an example of the extent of this interviewing, for 51 cerebral palsied children in the Sheffield area (out of a total of 202 handicapped children) there were 445 interviews. This study represented a somewhat different approach to the investigation of such problems as: (1) the needs of children with different handicaps and at different stages of growth; (2) the family circumstances of handicapped children, as they affect parents, the handicapped children themselves, and siblings; and (3) the community resources for meeting the needs of the handicapped child and his family. In view of the importance of home background and home care of the handicapped child, with the emotional and practical problems involved, and in view of the possibility of gaps in medical, educational, and welfare services for the child, it was felt that this type of investigation might throw new light on the difficulties, problems, experiences, and needs of parents and children. It is this kind of assessment of needs and recommendations for the future which provides a solid basis for planning to meet such needs (96).

A diversified program of research is sponsored by the Medical Research Council with government funds. The Council operates two national institutes for medical research at Mill Hill and Olmstead, London, and supports 70 smaller establishments known as Medical Research Council Units, which are groups attached to universities and hospitals. Short-term grants are also given to independent workers in universities, hospitals, and local health facilities, and scholarships and fellowships to promising young persons for training in research methods.

A collaborative research investigation concerning services for the mentally subnormal is being sponsored jointly by the National Association for Mental Health, the National Society for Mentally Handicapped Children, and the Spastics Society. The £10,000 to defray the costs of this two-year study of hospital and local authority services is being furnished by the latter two organizations (4, 267). The National Association for Mental Health has also accepted responsibility for raising during the next ten years the sum of £250,000 to finance a study of the learning processes of mentally backward and subnormal children (334) to be conducted by an Institute for Special Education at the University of Manchester. The primary purpose of the Institute is thus to be fundamental and applied research rather than teacher training.

Among the voluntary organizations established primarily for research purposes is the National Fund for Research into Poliomyelitis and Other Crippling Diseases (Polio Research Fund), which

was founded in 1952. As the title indicates, its basic purpose has been to raise funds to support research. Up to 1959, the emphasis was entirely on polio, but at that time, when it appeared that the use of vaccines would gradually diminish the incidence of polio, the title was extended to include other crippling diseases for which research was also needed. The research is now concerned, as in the parallel organization in the U. S., with the cause, prevention, and cure of all crippling diseases. Grants are also given for research abroad as in the case of a recent grant to the University College of East Africa at Makerere, Uganda, and another to University College of Ibadan (380).

When the National Fund for Poliomyelitis Research was first established, the Medical Research Council gave advice concerning the use of funds for appropriate research. Later a Scientific Advisory Panel was formed, with one member representing the Medical Research Council.

Among the special devices yielded by this research, which can aid persons with various kinds of physical disabilities, have been an inexpensive microfilm book projector, an electronic typewriter, and an artificial muscle to translate brain signals and operate a powered arm. Research in virology and bacteriology predominate, followed by artificial aids, leprosy, multiple sclerosis, muscular dystrophy, and diabetes, with specialist studies in pathology and orthopedics (161).

Other groups are increasingly concerned with research rather than with services alone. The Muscular Dystrophy Group of Great Britain, whose "overriding objective is to find the cure" (229) spends over half its annual budget for research (227). The organization supports research programs in more than 20 centers, usually in universities and teaching hospitals, by grants totaling over £100,000 per year. The work includes studies of the anatomy and physiology of muscles, muscle changes in disease, electrical changes in diseased muscles, and the chemistry of muscle tissue and the changes in disease (278). The Leicester branch of the Muscular Dystrophy Group has been most concerned about teenagers who suffer from muscular dystrophy. At its annual meeting in February 1963, it was urged that the authorities find out how many dystrophy youngsters in the country could be trained to do light work. Once the numbers could be determined for the Leicester area, a member of Parliament could be approached to see if the problem could be discussed by a higher authority (224).

Even when the sole or primary purpose of a voluntary organization is not research as in the preceding examples, research is still in most cases a part of the total contributions made by the society, either through programs undertaken by the group itself or through projects encouraged by the organization. For example, the 1962 Annual Report of the Central Council for the Disabled states first on

its list of objectives the purpose "to investigate the causes of crippling and promote measures for their elimination" (21). The report further stated that during 1962 the Council became increasingly active in the field of research concerning the difficulties which activities of daily living present to the handicapped, culminating in its exhibit on housing for the disabled in October of that year. The 1964-65 annual report of the Council listed the following research programs: (1) a continuing study of environmental barriers by the Disabled Living Activities Group of the Council; (2) a pilot study of the clothing problems of the disabled, undertaken by two occupational therapists; (3) a study of the availability of information about the disabled, with the aim of collating it concisely and simply under headings such as daily living, design and construction, education, training, employment, accommodation, and extra services; (4) special studies of problems of space and equipment such as the problems of the wheelchair disabled and those of ambulant arthritics (25). One of the most recent studies conducted by the Disabled Living Activities Group has been an assessment of the suitability of ten different kinds of door handles; the preferred type proved to be a large lever kind of handle, flattened horizontally, set well out from the door, with an upward convex curve to fit the palm (285).

Research is also one of the primary concerns of the British Council for Rehabilitation of the Disabled. This organization sponsors special committees to investigate problems faced in the field of rehabilitation. Recent examples of the subjects of such inquiries have been: the employment of people with cardiac difficulties; the employment of people with gastric and duodenal ulcers; and, most recently, the handicapped school leaver (9). Such findings are disseminated by means of various publications, including a journal distributed to 39 countries.

Along with its many welfare services, the National Deaf Children's Society has emphasized the need for basic research concerning the condition of deafness. On April 6-7, 1963, for example, the organization held a conference of research workers on the problems of deafness in children at Pembroke College, Oxford. A brief preliminary report on this Symposium for Research in Deafness in Children appeared in the Spring 1963 issue of the society's publication, "Talk." The society is much concerned about the urgent need for more scientific knowledge about all factors involved in the development of the personalities of deaf children. The organization has a Medical Research Committee, composed of leading otologists and an educational psychologist, and an Education Committee, composed largely of teachers, which are investigating these respective fields (259). It is recognized that research is needed particularly concerning the social adjustment of deaf adolescents, and information concerning this subject is expected to emerge from a current three-year

research program undertaken at the University of Manchester (59).

The most famous research concerning deafness, however, is that of the Ewings. The experimental work of Sir Alexander and his wife, the late Lady Ewing, has gained international recognition, and a long series of publications has reported their findings.

The importance of research in approaching the problems of the handicapped has been further demonstrated by the Mary Marlborough Lodge Disabled Living Research Unit at Oxford, established in 1960 on the grounds of the Nuffield Orthopaedic Center at Oxford. The unit accommodates 12 persons in addition to two resident staff members, and has a total staff of about 8 persons (386).

It is possible to cite here only a few specific examples of the kinds of research undertaken concerning the handicapped and their needs in England and Wales, for it is difficult to give a comprehensive picture of the variety and extent of such research. These illustrative studies should at least indicate the basic significance attached to research, and the diversity of the problems which are being approached.

THE ROLE OF VOLUNTARY SOCIETIES

Voluntary societies play a very important role in the provision of various kinds of services for the handicapped. The general pattern of development in these services has been the increasingly significant role of statutory agencies, accompanied by continued cooperation with voluntary organizations.

Some idea of the variety and scope of voluntary organizations in Great Britain can be found by examining the 1960 handbook and directory of "Voluntary Social Services" issued by the National Council for Social Service, itself founded in 1919 (257). A table in this directory indicates that the great majority have appeared in the twentieth century, with only three originating before 1800:

<i>Period</i>	<i>Number of organizations</i>
1650-1799	3
1800-1849	12
1850-1879	29
1880-1889	19
1890-1899	17
1900-1909	17
1910-1919	42
1920-1929	35
1930-1939	51
1940-1949	60
1950-1959	22

Nearly three-fourths (74%) have appeared since 1900, and 68% since 1910, with high frequencies at those intervals including the two world wars.

The National Assistance Act of 1948 gave permissive powers to the local health authorities to work with or through voluntary agencies. In other words, the local authorities either provide their own welfare services, or they can delegate voluntary groups to provide part or even all of these services, subsidizing the agencies accordingly. Close cooperation between, and integration of, statutory and voluntary services are considered necessary in order to provide efficient service and to avoid duplication of services. It is found that voluntary societies bridge the gap of lack of information as to the services available, and provide contact with those who need the services. Personal service rather than material help is now the main function of voluntary groups in the field of social welfare (200). A detailed discussion of the work undertaken by statutory and voluntary agencies, and their patterns of cooperation in providing services, is given in a 1959 Ministry of Health report on social workers in local authority health and welfare services (206).

The Ministry of Health continues to urge local authorities who have not already done so to establish formal contact with local voluntary organizations in order to make their needs known. An informal survey carried out by this Ministry in 1962 indicated that four out of five authorities had made contact with local voluntary bodies since the Circulars recommending this practice had appeared, and three out of five were making arrangements for regular contact so that service could be coordinated. In turn, many voluntary groups were taking the initiative to pursue the matter through special meetings, new publications, and special addresses at annual general meetings (200).

The continuing need for cooperation with voluntary groups is underscored by the basic problem that England is planning a major expansion of social welfare at a time of acute shortage both of funds and of trained personnel. For example, the Ministry of Health stated in a 1963 report that in the last five years current expenditure for health and welfare had risen by 50% and capital expenditures had quadrupled. This report represented the long-term planning (1962-63 to 1971-72) of the 146 local health authorities for those matters subject to such long-term planning, but did not include School Health and Child Care. An increase of 45% in the staffs employed was envisaged for statutory agencies alone (200).

Shortages in funds and personnel thus make it impossible for local authorities to meet present and future welfare needs themselves. Some authorities still prefer to delegate part or all of such responsibilities to voluntary agencies; this is done for work with the deaf and also for much of the work with the blind. There are even now

areas, however, where no systematic provisions are made, and almost everywhere there are gaps in the services. In some areas local authority planning has led to the formation of a new voluntary body working in close cooperation with the public agencies, or the reviving and reactivation of a declining voluntary service. The most unusual development has been the emergence of organizations serving particular forms of handicap, a phenomenon which has also been found in the United States (286).

It appears that the volunteer will continue to be a valuable adjunct for statutory services, especially in view of present emphasis on community care.

There are some services in the home which can best be performed by the volunteer representing the community in a sense that no statutory officer can achieve. The volunteer goes into the home, not to provide a specific service — there a trained worker is necessary — but with the intention of bringing the community into the home (286).

This implies that the volunteer is carefully selected and receives some training, not to make the volunteer a trained social worker, but as in the wartime auxiliary services, to make him a trained volunteer.

The most obvious use of the volunteer is therefore to relieve the professionally trained worker of tasks which can well be carried out by the amateur with some degree of training. The volunteer worker needs to know when to call in expert help, and where to find it. The British Red Cross Society offers a certified welfare course as well as a non-certificated shorter one for such a worker. Marriage Guidance Counsellors have an approved course of training, as do the workers employed by the National Citizens' Advice Bureaux (286).

Thus the English feel that while there will continue to be great need for the services of specially trained experts such as social workers, the importance of the voluntary worker should not be underestimated. For example, basic loneliness and a feeling of isolation from the normal community may be a very acute problem faced by many of the handicapped, and the volunteer can do much to draw them into the mainstream of life and give them a feeling of social acceptance. School groups, youth organizations, as well as many individuals can do much to make the handicapped youth feel wanted and welcomed. An encouraging example of such effort is that of a small group of people who, having founded Voluntary Services Overseas, are now trying to provide opportunities for social service for young people who cannot go overseas. These young people are encouraged to act as "elder brothers" to some of those who have to face the outside world without such support. They come from a variety of backgrounds: Some are pre-university candidates; some

are police cadets; some are industrial apprentices, chosen like the others with great care and sponsored by major firms in the belief that exposure to problems of this kind will increase their sense of social responsibility. Some of these young people are attached to schools for the handicapped, mental hospitals, residential training centers, and sheltered workshops. The initial attitudes of distrust and suspicion which they encountered are giving way to a greater appreciation of what young people can do to help (10).

In some respects the differences between voluntary and statutory work are probably less marked today than they used to be. Both groups sponsor research, often collaborating in special projects. The experimental work of voluntary organizations is still highly praised, but the days of a strictly voluntary society working without state or local authority assistance of any kind are at an end (93). Also, whereas once it was always assumed that legislation follows where voluntary effort has led the way, experimentation is no longer confined to voluntary groups. Local authorities and other public agencies have the power and increasingly the motivation to try out programs for which there has been no precedent, with the support and encouragement of the Ministry concerned. Voluntary organizations in turn rely increasingly on the services of professional staff and on grants from the public authorities to pay their salaries. And though voluntary groups may be less hemmed in by regulations than public authorities, trust deeds may on the other hand narrow the focus of voluntary activities and prevent adaptation to a changing social picture—"a long history can be a handicap as well as an inspiration" (286).

Voluntary groups continue to seek ingenious methods of financing their efforts, since public tax money rarely provides more than a part of their expenditures. In Liverpool, for example, the joint efforts of the Council of Social Service and the Personal Service Society have led to the setting up of a new organization, United Voluntary Organisations, which, with the cooperation of the employing groups and the trade unions, collects weekly pennies from between 60,000 and 70,000 persons working in approximately 550 firms and distributes the sum so collected annually among the local charities associated with the system. This represented a kind of United Fund effort, but on a continuing basis rather than as an annual drive. Manchester has started a similar arrangement, and other cities are about to follow suit (93).

Another interesting method of financing voluntary efforts is that of the Friends of Spastics football pool. There are 6½ million members in this football pool run by professional promoters. It is the chief source of funds for the Spastic Society. The pool is for football in winter and cricket in summer.*

* Interview with Mrs. C. Clifton, Spastics Society, July 1963.

It has been pointed out that many new voluntary organizations are devoted to a specific disability. There are certain common characteristics found in these groups, regardless of the persons served. Most of them have local branches which hold regular meetings and organize a variety of activities. They all provide an advisory service for members, seek to bring their needs and problems to the attention of the public, try to protect them from prejudice and unfair discrimination, sponsor research into the causes and treatment of the disability concerned, and urge better public provisions. Lay control is a matter of principle; some societies even have rules restricting the percentage of practicing doctors who can be members of the governing body. This lay control is in the hands of adults with the particular disability and parents of children with the disability. But such groups also show some differences. For example, they vary considerably in the extent to which they provide services themselves for the persons with whom they are concerned. There is difference of opinion as to whether membership should be limited to the handicapped persons and their families. These special-interest organizations have at times been criticized for not basing their provisions on careful assessment of the need for these provisions, or for not defining clearly the degree of disability for which the organization is intended.

In actuality, a striking feature of voluntary activities in general is their diversity and variety rather than their uniformity. The variations in policy and practice in voluntary services for the physically handicapped are apparently typical of English voluntary effort as a whole. Voluntary organizations serving this group have had divergent concepts regarding the following questions: (1) the circumstances under which the handicapped should be separated from or integrated with the non-handicapped in education, training, rehabilitation, employment, welfare, or residential care; (2) the scope of the work of the voluntary group, varying from the more inclusive categories of older societies to the dozen new organizations serving a specific disability group, such as cerebral palsy or muscular dystrophy; (3) the degree of medical supervision desirable once the stage of treatment is past; (4) the function of the sheltered workshop, either as an end in itself or as a gateway to open employment; (5) the kind of work to be provided in the sheltered workshop, whether skilled crafts requiring long periods of training as in the older enterprises or the more recent attempts to make mass-produced articles with machine processes that can be subdivided into operations which can be learned easily; (6) the range of handicaps to be included in a workshop, and the proportion of able-bodied workers included; (7) the specific role to be played by voluntary groups in providing employment; (8) the role to be played by voluntary societies in providing local welfare services; and (9) the question as to

whether, in either short-term or long-term residential care, the specialized or the mixed group is preferable (286).

In spite of differences in policy and practice, there is continuing effort to coordinate provisions among the voluntary organizations themselves and between the voluntary and public agencies. In some areas there are committees to bring together representatives of the statutory and voluntary agencies dealing with the welfare of the physically handicapped. Representatives from such committees are brought together by the Central Council for the Disabled (affiliated with the International Society for Welfare of the Disabled), which is also responsible for a national standing conference for delegates from the agencies concerned with the disabled. Other national organizations such as the Royal National Institute for the Blind and the Royal National Institute for the Deaf perform similar important services for their disability groups. The National Association of Mental Health has tried to coordinate the efforts of the National Society for Mentally Handicapped Children with other groups that have become further differentiated such as the Society for Autistic Children and the Society of Parents of Autistic Children. Joint conferences often serve this purpose. Furthermore, the unfortunate gap created by placing mentally subnormal children under the health authority, is bridged in part by conferences arranged by the National Association of Mental Health, which brings together those working with ESN children and those working with the so-called mentally subnormal who are considered "unsuitable for education in school."

Members of the staff of the National Council of Social Service are associated with 91 other agencies through participation in the work of committees and working parties, as described in a recent annual report of the organization (256).

The voluntary society in England and Wales thus remains an integrally important part of the program of services available to the population of about 55,000,000 people. Although its role has changed, there is no possibility that it will disappear. Working in intimate cooperation with statutory agencies, the voluntary society will continue its role of providing a better life for the handicapped.

POSTSCRIPT

The English are critical of the existing range of the services they offer to handicapped youth. A representative sample of needed changes and improvements cited by English publications indicate the following:

1. General needs

- a. Continued change in the direction of more positive public attitudes toward and understanding of the handicapped, especially such groups as the deaf and the mentally handicapped.
- b. Changes in terminology such as "educationally subnormal" and "mentally subnormal" to give a more constructive emphasis.
- c. Increase in the scope of, and coordination of, rehabilitation services, especially in the recovery phase of illness, with a common policy defined for the agencies concerned.
- d. Closer coordination between local-authority and voluntary services to avoid inefficient duplication or overlapping of services.
- e. Closer contact between hospital and home through an extension of social work.
- f. Continuity of aid to be provided by a single advisor to follow the handicapped youngster through school and post-school life, to maintain links with the various medical, educational, and social services involved, and to have personal contact with the youngster and his family.
- g. More adequate provision of help for the family of the handicapped youngster at all stages of their relationship with him, in terms of information, reassurance, training suggestions, and practical help with the physical and financial aspects of his care.

2. Needs in special education

- a. Improvements in physical plant.
- b. Expanded programs, including further education.
- c. More training courses for special teachers.
- d. More trained personnel, including social workers and educational psychologists, of whom more should be trained each year.
- e. More experimentation and research, followed by a planned, organized application of findings rather than a piecemeal system.

- f. Expansion of the dental service, which is said to lag behind other aspects of the School Health Service, and the child guidance services.
- g. More adequate assessment of the present and future needs of youngsters with various kinds of disability, as a basis for improved programs.
- h. Removal of the arbitrary distinction between education for the educationally subnormal child and training for the mentally subnormal child.

3. Vocational (work-related) needs

- a. More effective services for the transition from school to job.
- b. More involvement of psychologists in various aspects of the transition period.
- c. More research concerning vocational guidance methods, training methods, and employment prospects of various groups of the handicapped.
- d. Better coordination between governmental and voluntary agencies at this point, and between labor agencies or industries and the schools.
- e. Improvement in employer attitudes toward hiring the handicapped, especially specific groups such as the epileptic and the mentally handicapped.
- f. Closer interrelationship between the vocational training given the handicapped and the job opportunities open to them.
- g. Realistic assessment of job demands and skills in relation to the capacities of the handicapped, with a recognition of the changing employment picture.
- h. Expanded opportunities on higher levels such as university education, administrative and executive positions, and the professions.
- i. Closer liaison between the youth employment officer and the Appointed Factory Doctor.
- j. Specific training of the youth employment officer concerning the special needs and problems of handicapped school leavers.
- k. Integration of local-authority and Ministry of Labour youth employment services to avoid the duality of industrial versus educational emphases.
- l. More youth employment services for the grammar school.
- m. More and better sheltered workshop opportunities for the severely handicapped, with an adequate geographical distribution.

- n. More emphasis on the sheltered workshop as a point of transition to community life and the open labor market rather than as a terminal assignment, as indicated in part by its location.
- o. More emphasis on the development of marketable skills and the performance of useful work rather than busywork in the sheltered workshop.

The general changes recommended are familiar since they represent the kinds of improvement that experienced and knowledgeable professionals are working for in all countries where basic programs have been established. It seems evident that the services provided in England and Wales compare favorably with those of the more progressive American states, though the English services undoubtedly are more successful in reaching the people who need them than is likely to be the case even in these states. Many American states and communities have a considerable distance to go before they reach the English standard of services for handicapped youth.

Outstanding features of the English system as compared with the United States include:

- 1. More likelihood of a close interrelationship between governmental and voluntary agencies, with subsidies for the latter.
- 2. A more broadly inclusive program of health services, with an emphasis on public rather than private practice.
- 3. Greater reliance on studies made by public-spirited citizens and civil servants from all levels of government.
- 4. Somewhat different services from government agencies such as those provided by the youth employment officer, the Disablement Resettlement Officer, and the Appointed Factory Doctor.

Although the political, social, and economic conditions in England and in the United States are not the same, students and professionals from each country are finding that studies of arrangements and services in the other country are rewarding in providing perspective and illumination concerning their own work, and in enhancing their chance to improve the extent and quality of their own services.

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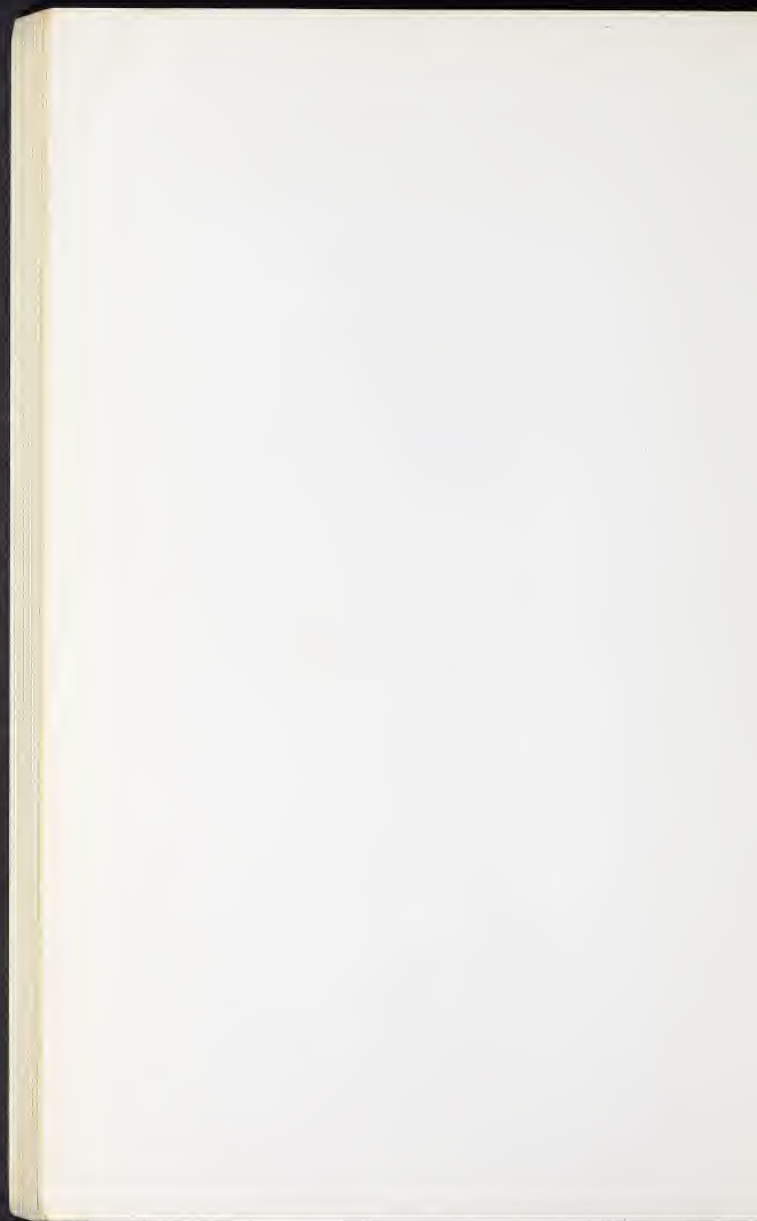
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December 28, 1966

MEMORANDUM FROM: Mrs. Dorothy Warms
Acting Secretary General

I am pleased, on behalf of the International Society for Rehabilitation of the Disabled and its World Committee on Special Education and World Committee on Research in Rehabilitation, to forward you this copy of our new publication SERVICES FOR HANDICAPPED YOUTH IN ENGLAND AND WALES, by Wallace W. and Isabelle W. Taylor.

THE PROFESSORS TAYLOR ARE THE AUTHORS OF "SPECIAL EDUCATION OF PHYSICALLY HANDICAPPED CHILDREN IN WESTERN EUROPE", PUBLISHED BY THE INTERNATIONAL SOCIETY IN 1960.

This new investigation was supported, in part, by a research fellowship and a research demonstration grant (No.536) from the Vocational Rehabilitation Administration, Department of Health, Education and Welfare, Washington, D.C. 20201. Additional single copies are available without cost, upon request to the International Society for Rehabilitation of the Disabled.

Professors Wallace and Isabelle Taylor are spending the period of February through May, 1967, gathering data for another publication on SERVICES FOR PHYSICALLY HANDICAPPED YOUTH IN ASIA. This investigation is also being conducted under the auspices of the International Society for Rehabilitation of the Disabled and is being supported, in part, by the Vocational Rehabilitation Administration, U.S. Department of Health, Education and Welfare.

Erratum: Please change "dollars" to "pounds" in line 12, page 9.

